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ABSTRACT

This proceedings document includes papers presented at a conference on children's mental health, systems of care, and research. Papers are grouped into 11 chapters which address the following topics: (1) program and system evaluations (nine papers); (2) managed care in children's mental health (six papers); (3) accountability and information systems (three papers); (4) evaluating wraparound services (two papers); (5) family perspectives (six papers); (6) interagency development and evaluation (seven papers); (7) crisis services and residential care (six papers); (8) service utilization and clinical issues (eleven papers); (9) school-based models (six papers); (10) assessment of service and training needs (five papers); and (11) instrumentation and methodology (thirteen papers). (Individual papers contain references.) (DB)

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Cindy Liberton, Krista Kutash, and Robert M. Friedman, Editors

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Chapter 1

Program & System Evaluations

Issues in Developing and Evaluating Family Support Programs

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Introduction

Family support programs have been implemented across a wide variety of service systems for children and families (Ayoub, Daro, Landsverk, & Lutzker, 1996). Development of effective knowledge about "what works" in these programs has been hampered by a number of program implementation and evaluation issues (Pecora, Fraser, Nelson, McCroskey, & Meezan, 1995). These include lack of a coherent theory of family-based services, poorly specified program models, inconsistent referral and case targeting practices, absence of procedural guidelines for direct service issues (e.g., staff selection, training, and retention), and an inability to develop a systematic mechanism for monitoring program quality and refining the program as it stabilizes and matures.

In this summary, a local family support program is presented in order to illustrate these issues and highlight the importance of appropriate planning, monitoring, and evaluation of family support efforts. The Pecora et al. (1995) framework is also expanded by describing the significance of contextual factors which affect program implementation and evaluation; such a description has implications for third-party funders of services, providers, and evaluators.

Method

Total Family Strategy (TFS) is a home-based family support program funded by the Juvenile Welfare Board (JWB) of Pinellas County, Florida. JWB is an independent special taxing district that funds delivery of children's services through other community agencies (Juvenile Welfare Board, 1992).

This program was initiated by JWB as a means of introducing a family empowerment model of early intervention into the array of existing services for children and families. The goal of TFS is to prevent "million-dollar families" (Friedman, 1991), who could incur that amount in service system costs throughout the life of the family. The target population is young families with children under the age of 12 who are at risk of developing serious problems, and who have not already utilized significant social service resources. Four agencies in the community provide this service. Program components include case management, access to community resources, advocacy, and counseling. The University of South Florida, Florida Mental Health Institute (FMHI) has been involved from the inception of the program in conceptualizing the program and evaluating its impact.

Beginning in 1994, a process evaluation of the TFS program was conducted (Silver & Marfo, 1994). Multiple methods were used in the TFS evaluation, including (a) review of existing program descriptions and other documents, (b) interviews with agency directors and staff, and (c) quantitative analysis of data routinely collected from families (N = 93). Intensive case studies were also conducted with TFS families (N = 8) and staff.

Results

Process evaluation revealed a number of issues identified by Pecora et al. (1995) operating in the TFS program, as follows.

Under-specification of the program model. Interviews conducted with agency directors revealed different ideas about the purpose of the program, its target population, and indicators of program effectiveness. For example, responses to questions about the purpose of the program revealed a range of program philosophies, from a focus on preventing serious problems, such as out-of-home placements or juvenile delinquency, to an emphasis on empowering families to problem-solve, access resources, develop informal networks, and become more self-sufficient. These differences in program philosophy also occurred at the program staff level, as revealed by case study interviews and observations at monthly staff meetings.

Inappropriate referral and case targeting. Case studies and quantitative analysis indicated that many families being quantitative analysis indicated that many families being served in the program had already experienced significant systems involvement. Examples from the case studies included involvement in the child protective services system, adult corrections, and severe emotional difficulties. This population differed significantly from the one that the program was designed to serve; moreover, the population which was served varied by agency (Silver, 1995). Historic differences in populations served, referral sources, and funding sources may have contributed to different interpretations of the eligibility guidelines.

Program drift. The four agencies appeared to have a similar picture of the program model when the initiative began, as evidenced by a set of guidelines they had jointly developed. However, agencies appeared to interpret the guidelines differently, which led to differences in program implementation. For example, as a result of differences in agencies' staffing patterns, differences occurred in the degree to which therapeutic services, versus case management and referral, were emphasized in staff's work with families. Record-keeping procedures were modified to meet requirements of the larger agency, which sometimes affected methods used in family assessment and case plan development. Staff turn-over, combined with lack of detailed implementation procedures, increased the opportunity for differences in the interpretation of the program model.

Discussion

Process evaluation identified significant variation in agencies' implementation of this family support program. As a result of this and other information, program staff, JWB, and the evaluator are developing mechanisms to improve implementation on the issues described above.

There were important contextual issues in the current initiative that shaped program implementation, monitoring, and evaluation activities. The first issue pertains to the relationship between funders and service providers. In 1991, JWB and FMHI identified the need for an innovative service and sought to have this service provided by local agencies. The impetus for the initiative came from outside the agencies. A second, related contextual issue is that the model underlying TFS represented a change in agencies' existing practices. Total Family Strategy emphasizes a home-based (versus office-based) model, working with families holistically instead of with the identified client. Additionally, TFS focused on partnering with families, building on their strengths and providing community-level supports, as opposed to employing the traditional therapeutic approach. Despite the joint development of program guidelines, the process evaluation indicated that agencies were operating with different interpretations of how this model translated into practice. This underspecification of the program model led to uneven program implementation across agencies.

Contextual factors also affected quality control and program evaluation activities. Initially, neither JWB nor FMHI fully realized the complexity of this initiative, including the time needed to implement and bring about the desired changes. As the program developed, recognition of the necessity for developing new approaches to contract management and evaluation also occurred. "Lessons learned" included changing from a practice of separate JWB contract managers (i.e., one for each agency) to one contract manager who worked across all four agencies and assumed a greater coordinating role.

Pecora et al. (1995) note that one of the pitfalls of evaluating programs is a mismatch between stage of program development and evaluation design. The initial evaluation design focused on short-term outcomes (i.e., an approach consistent with JWB's practice of monitoring contracts with established programs). As the complexity of managing this program revealed itself, JWB requested an evaluation plan that included both process and outcome components. Process evaluation revealed a number of issues that will impact long-term evaluation of this program (e.g., the differences in the populations served by agencies will require analysis of families' long-term progress separately for each agency). This has led to a clearer understanding of the limitations of the evaluation that would not have been achieved without a focus on process evaluation.

The nature of family-support programs affects the context, implementation, and evaluation of programs. Family support services offer a wide breadth of services, and issues faced by families represent multiple domains (e.g., housing, basic needs, transportation, additional education/training, parenting support, and counseling). The heterogeneity of the target population poses significant challenges for family support programs. In the current program, these challenges may have been compounded by the difficulty of operationalizing characteristics of those likely to become "million dollar families." In addition to significant process evaluation issues, family support programs present formidable challenges to outcome evaluation. Evaluation is made more difficult by the use of individualized criteria for determining family progress and success, and by the fact that family success is also dependent upon available and accessible community resources&endash;issues which are often not under the control of program staff (Silver, 1995).

Experience with the TFS evaluation leads to several recommendations. These recommendations apply to funders, providers, and evaluators of family-based programs. The importance of careful, systematic implementation planning cannot be overlooked. This starts with review of Pecora, et al.'s (1995) description of the issues involved in implementing and evaluating services. It is also crucial to allocate sufficient time and resources to monitor program implementation. The specific strategy used to monitor implementation can take a number of forms. These include having the funder and providers develop self-assessment mechanisms that would include "benchmarks of progress" to determine whether program implementation is on track (e.g., Is there a mechanism for regular review and refinements of the program model? What information is being collected to provide feedback about these issues?). If the time needed to develop, implement, and monitor the program exceeds that of the funder and/or providers, consider having an external evaluator conduct a process evaluation. A third strategy combines elements of the first two (e.g., having an evaluator provide technical assistance on developing self-assessment measures).

Carefully consider the context in which this new program is being implemented. Is this an innovative service that challenges traditional practices? Who is in charge of the innovation? How does this model fit with existing philosophy, practice, and training of providers? What group processes can be used to facilitate the empowerment of providers and their ownership of innovation? Be sure to define roles, including the role of the evaluator. Consider how the role of an evaluator can be utilized to help develop a more participatory approach to program evaluation (e.g., as a participant observer who provides technical assistance and helps facilitate the group process, vs. a traditional evaluator that may lead providers to comply, rather than take risks and try an innovation).

The process issues described in this summary raise questions about how providers and funders can work together to develop and deliver innovative family support programs. Developing mechanisms to foster collaboration may be especially important when the new initiative requires changes in existing funder-provider relationships and staff practices. These issues are likely to grow in importance as family support programs grow and pressures for greater accountability of programs increase.

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Child Level of Functioning and Intensive Family Preservation: An Examination of Colorado's Mental Health Family Preservation Programs

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Introduction Method Results Implications References

Introduction

Intensive family preservation services (IFPS) have emerged as a service innovation in both the child welfare and children's mental health service systems. IFPS interventions involve the provision of intensive, home-based, skill-focused services to families whose children are at imminent risk of placement. Colorado has implemented IFPS as part of its system of care for children with emotional disabilities and their families. Existing research on IFPS focuses on the child welfare system, with primary attention given to the outcome of placement prevention. Increasingly, the focus is shifting toward direct measures of client functioning and its relationship to placement prevention. Several studies (Nelson, 1988; Bath, Richey, & Haapala, 1992; Fraser, Pecora, & Lewis, 1991) indicate that problems in children's functioning are correlates of placement.

For the children's mental health system, child level of functioning is an increasingly important variable, with interest driven by (a) theoretical shifts from psychodynamic and behavioral models toward ecological models for intervention and research, and (b) measurement issues, moving from diagnostic categories to Level of Functioning (LOF) measures. One such measure is the Colorado Client Assessment Record (CCAR) which assesses nine, domain-specific areas of functioning (Ellis, Wackwitz, & Foster, 1991).

This summary focuses on three areas of investigation: (a) description of the mental health family preservation intervention, (b) validity of the CCAR as a measurement of children's level of functioning, and (c) identification of the multivariate predictors of placement.

Method

Service Context of IFPS in Colorado's Mental Health System

Establishing a complete description of service innovations is imperative prior to examination of client outcomes and correlates of those outcomes. In addition, existing research in family preservation indicates that heterogeneity of service evolution is common across sites (Schuerman, Rzepnicki, Littell, & Chak, 1993; McDonald & Associates, 1990). Site visits were conducted at each of the eight IFPS service sites, including interviews with 26 program directors, supervisory, and service staff. Qualitative interview data was gathered in the form of taped interviews, each of which followed a semi-structured interview guide focusing on service philosophy, intervention models, and agency-community contexts.

The differing environments in which programs operate have driven slight divergence in program models, with the primary impacts on intervention length and mechanisms for program access. These differences are small, however, and must be considered in the context of the many similarities among service sites. Programs evidenced striking similarities in philosophies of service and types of interventions offered. The dominant service themes were: (a) the power and nature of the helping relationship, (b) the strength of the crisis intervention/brief intervention foundation, and (c) the commitment to skill-focused intervention.

Factorial Structure of the Colorado Client Assessment Record

Level of functioning measures can provide information important to tailoring interventions, predicting success of these interventions, and describing outcomes. The CCAR is administered for all Department of Mental Health (DMH) clients, including children; however, no exploration of its factorial structure had been done for a child mental health population. The CCAR assesses mental health functioning in nine domains (Feeling/Mood/Affect, Thinking, Medical/Physical, Substance Use, Family, Interpersonal, Role Performance, Social Legal, and Self care/basic needs) using a combination of rating scales and checklist items. In order to explore the utility of this measure, it was hypothesized that the nine factor model which forms the conceptual organization of the instrument best fits the data obtained from DMH clients.

Each of the nine Level of Functioning (LOF) scales is measured on a 0 to 50 point scale. Of 78 problem checklist items, 69 are conceptually linked to the specific level of functioning scales and describe attributes of the client and the client's interaction with their environment. Fourteen Personal Problem Profile (PPP) scales were developed from these checklist items.

these checklist items.

Subjects

The sample consisted of a randomly selected group of 5,000 child recipients of mental health services. Data from a 50% sample was used for exploratory factor analysis: scores from the remainder were used for confirmatory factor analysis, using the EQS structural equation modeling program.

Results

Analysis

The 9 Level of Functioning scales and 14 Personal Problem Profile scales were submitted to exploratory factor analysis using maximum likelihood factoring and oblimin rotation due to the theoretical likelihood that dimensions of functioning are inter-related. Using the 1.0 cutoff for evaluation of eigenvalues, a seven factor solution emerged explaining 49.7% of variance, with all LOF scales factoring with their associated PPP scales. Two sets of LOFs and PPPs factor together: (a) Thinking and Self care/Basic needs, and (b) Role performance and Socio-legal. Correlations between factors range from .04 to .43.

Because of the theoretical interest in a nine factor model, this solution was also examined (see Figure 1). This model explains 56.3 % of the variance. All PPP indicators load strongly with their associated LOF scales on a separate factor. No indicators cross load to other factors. Correlations between the factors range from .05 to .46. Both models were carried forward into the confirmatory factor analysis (CFA) using EQS (Bentler, 1989).

The seven factor model did not fit the data, with a CFI of .796. Examination of the modification indices indicated that upwards of 20 cross loadings of indicators were necessary to achieve adequate fit. The nine-factor model was also tested. Maximum likelihood factoring was used, and no special problems were observed during optimization. This model exhibited improved fit, with a CFI of .867, and examination of the modification indices indicated that relatively few cross loadings were necessary to achieve fit. Allowing five of 23 indicators to cross load produced a model which fit the data with a CFI of .900. Three of these cross loadings, however, were very small (i.e., less than .2). The standardized structural matrix is presented in Table 1.

It is important to consider possible reasons for inadequate fit of the hypothesized model. The model may simply not fit these data because it does not contain important theoretical elements. However, there may also be technical reasons. Monte Carlo studies indicate that "large" models, even when known to fit perfectly, generate fit estimates lower than "small" models. In addition, while large sample sizes are needed to achieve stability in matrices, very large sample sizes impose power constraints on model fitting, as sample sizes impose power constraints on model fitting, as do high factor loadings (Gerbing & Anderson, 1993). In this model, factor loadings are high, and the sample and model sizes are large.

Given the evolving understanding of model fit in the field of structural equation modeling, it would be premature to reject the hypothesized 9 factor model based on the .90 cutoff for the CFI. These analyses do support the use of the existing Level of Functioning scales, which were carried forward into subsequent multivariate analysis.

Multivariate Predictors of Placement Outcomes

While level of functioning data are instructive, LOF is only one variable among many that contribute to the impact of an intervention for individual families. To identify which variables had the most power to predict placement outcomes for the family preservation intervention, we looked at a family preservation sample that consisted of the 316 children who received family preservation services between 1990 and 1992. Data collected included information on demographics, child level of functioning (CCAR), service needs, interventions, and placement outcome. Logistic regression models, using backward selection with a likelihood ratio criteria, were developed to examine the correlates of placement prevention and to construct a predictive model for placement.

Results showed that prediction of placement was dependent on the time frame under consideration, with models differing completely for placement within 3 months of service, and placement following 3 months of service. During the first 3 months post-termination, children's level of functioning on the CCAR's socio-legal domain, a previous group home placement, and presence of parental mental health service needs, increased the odds of placement (see Table 2). The only service variable which was related to placement was the sheer number of follow-up services available which reduced the risk of placement by 26% for each service.

For the 3-6 month post-intervention time period (see Table 3), two variables were related to reduced risk of placement. Families whose children were at risk of foster care (rather than more intensive levels of care) were at 80% less risk of placement. Families whose service focused on managing child behavior were at 90% less risk of placement. In contrast, families whose service focused on substance abuse and very basic life-management skills were at greatest risk (5.7 and 10.0 times the risk of other families, respectively).

Implications

Model Fit: Implications for Program Decisions

Information from predictive models can be used in two ways at the program level: (a) to make decisions about the ways at the program level: (a) to make decisions about the structure of interventions, and (b) to make decisions about access to services. In general, risk and protective factors, and the models built of them are not sufficiently accurate in their prediction of failure to warrant denial of access to services. This information is, however, useful in examining the intervention so as to structure it to maximize use of protective factors and craft interventions to focus on risk factors.

This was certainly true for the models which emerged from this study. Although the overall models for the separate time periods fit the data relatively well, they did not predict placement very well. In both cases, the model did a good job of predicting which children would not be placed (correctly classifying 99% of these cases), but a very poor job of predicting which children would be placed. The latter is, of course, of the most interest for restricting access to services. The predictive model for the 3-6 month time frame was the best, predicting placement at 50% accuracy; however, this resulted in little practical usefulness.

Thus, these results are useful in considering which families may be at increased risk of placement for the purpose of designing or re-designing the targeted intervention package for families with these characteristics. These results are not useful in making screening decisions regarding access to services.

Several findings are important for program design. Clearly there is need for focus on short and long-term program strategies for prolonging durability of the intervention. Many family preservation programs focus on internal family functioning. However, programs must also address children's functioning in the legal realm and promote strong connections to follow-up services. As we look at families "down the road" from intervention, it is clear that families facing substance abuse and extreme family disorganization are much less likely to maintain gains, which again places an emphasis on a strong continuum of care and on intervention focus in these areas.

Implications for Future Research

With regard to the CCAR, there is need for additional work in specifying the structure of the instrument. There is also a need to examine the concurrent validity of the instrument by comparing it to other measures of children's functioning. Another important area for future research lies in the examination of the instrument's sensitivity to change and the usefulness of change scores in assessing level of functioning outcomes.

Additional qualitative work is needed on client experience of the helping relationship. It seems likely that much of the power of this intervention lies in its approach to practice, specifically in the nature of the helping relationship. If service interventions were adequately modeled in quantitative ways, the task of measuring the quality of the helping relationship must be faced. An approach to measure development which is rooted in the experience of those involved in the helping relationship is imperative; especially when considering the experience of clients.

Family preservation interventions occupy a key place in the continuum of care. There remains a need to move beyond placement prevention to direct measures of client change, including exploration of changes in children's functioning and the relationships between client change and distal outcomes.

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Comprehensive Evaluation of Hawaii's Healthy Start Program

Authors

Introduction Method Results Discussion References

Introduction

Hawaii's Healthy Start Program (HSP) is a well established screening and outreach program with two components: (a) the Early Identification (EID) component which consists of community-based screening to identify newborns at environmental risk for child abuse and neglect and (b) the Home Visiting component which consists of in-home counseling by trained paraprofessionals to promote healthy family functioning and child development. The latter component consists of role modeling, education, and coordinated linkage with pediatric primary care and other needed community resources in the child's first five years of life.

The HSP program philosophy is to target high risk families, focusing on both personal and environmental determinants of parenting behavior, and to promote competence by "reparenting the parents." The first step is to encourage the parent's emotional dependence on the home visitor. Then, over time, the next steps are to help the parents to become self-sufficient (Breakey, Uohara-Pratt, Morrel-Samuels, & Kolb-Latu, 1991).

Nationally, there is strong endorsement for home visiting programs in general, and the HSP model in particular. Several unresolved issues, however, impede efforts to establish community-based home visiting programs: (a) mixed results of past evaluations, (b) limited study of non-nurse home visitors, (c) evaluation of demonstrations rather than established programs, (d) little research on the types of families most likely to benefit, and (e) uncertain cost-benefits of home visiting. These issues render evaluation findings essential for informed policy and program development (United States General Accounting Office, 1990).

This evaluation is a joint effort of the Johns Hopkins University, the Hawaii State Health Department, and the

Hawaii Medical Association (HMA). Funding for the evaluation is provided by the Robert Wood Johnson Foundation, the Annie E. Casey Foundation, the David and Lucile Packard Foundation, the Federal Maternal and Child Health Bureau, and the Hawaii State Department of Health. Participating programs and agencies include Child and Family Services, Hawaii Family Stress Center, Parents and Children Together, and the Hawaii Department of Human Services.

Method

The project is being conducted over five years, beginning in May, 1994. The evaluation addresses four research questions:

- How closely does program implementation mirror program design?
- How successful is the program in achieving intended benefits for children and families?
- How does fidelity of implementation influence program achievement of intended benefits?
- How do achieved benefits compare to direct and indirect program costs?

The evaluation focuses on six geographically defined communities on Oahu that are served by HSP program sites. A family was eligible for the evaluation if (a) the family was eligible for the HSP itself; (b) the family was identified as at-risk by an EID worker following the usual HSP protocol; (c) the family was not currently enrolled in the HSP for a prior birth; and (d) the mother did not need a translator (fewer than 3% of those eligible for the HSP).

Enrollment began on November 1, 1994 and continued through December 31, 1995, achieving a full sample of 685 participants. At each hospital on Oahu, HSP early identification workers (EID) followed the routine HSP screening/assessment protocol to identify infants born into at-risk families. By protocol, all families living in HSP catchment areas are screened and assessed. Those scoring ^{3} 25 on Kempe's Family Stress Checklist are defined as at-risk. If the family was at-risk, the EID worker described the HSP and its evaluation according to a standardized informed consent protocol and invited the mother to participate in the evaluation.

After the mother gave informed consent for participation in the evaluation, the EID worker called the evaluation fieldwork office to determine the family's study group assignment. Families were randomly assigned to an HSP intervention group, a main control group, or a testing control group. Each intervention group family was referred to the Healthy Start Program site serving its community and was offered home visiting services following the usual HSP protocol. Each main control group family was also given a list of community programs.

All families will be followed for three years. Key outcome variable indicators and measures to be collected annually are delineated in Table 1. In addition, data on maternal characteristics, maternal and paternal employment, maternal social support, maternal health and psychological well-being, maternal health care, child health care, need for parenting services, maternal and paternal substance abuse, paternal characteristics, and family income will be collected on the baseline interview as well as in follow-up interviews.

Analysis

The comparability of study participants and non-participants will be examined using standard techniques for the types of variables measured (e.g., Student's t-test for normally distributed variables, chi-square tests for binary data, etc.) for evaluation of all at-risk families at the time of the child's birth. In the same way, the initial comparability of the HSP and control groups will be assessed for these measures and for baseline interview variables. Overall process measures, outcome assessment, relationship between program process and outcome, and cost benefits analysis will be examined using standard techniques for the types of variables measured.

Within both the HSP and Control Groups, families will be categorized in terms of characteristics at the time of the child's birth: family ethnicity, initial risk assessment score, family substance abuse, family violence, and maternal age. For each outcome, multivariable models will be used to test for differences in outcome between the HSP Group and the Control Group in the presence of differences in initial risk and the degree of resolution of other outcomes.

Within both groups, levels of use and associated costs will be measured for health services, child protective services, police and legal services, and other community services. For families in the HSP group, direct program costs will be measured as well. Tests for significant differences in total costs per child between program and control group families will be computed using t-statistics, and controls for other factors that influence costs will be introduced via regression analysis.

Results

Exploratory analyses were conducted by running frequencies on all 522 variables for the first 664 completed cases in the database examining distributions and summarizing responses in terms of central tendency and dispersion. Eighty-two percent of the families that were eligible for the evaluation are participating in the study. At this point, no differences in the comparability of study participants and non-participants have been detected.

Comparability of Groups

Comparison of Study Groups, the Healthy Start Program Group, and the Control Group are comparable in terms of demographics (see Table 2). The only area where p approaches significance is in the Mother's Employment in the Past Year. We will control for this difference as needed in subsequent analyses.

Family Needs

The baseline interview contains items pertaining to: (a) the mother's current receipt of financial, nutritional and housing assistance; (b) her perceived need for nutritional, housing, vocational and child care services; and (c) her emotional health. Table 3 summarizes the percent of mothers in the first 664 cases analyzed who report using or needing financial, nutritional, housing, educational, vocational, child care, and mental health services. Family needs associated with teenage childbearing, domestic violence, problem alcohol, and other drug use are discussed below.

Most mothers qualify for the state's health coverage program, QUEST, which is targeted to low income families. Over two-thirds of the mothers live in households with income below the poverty level, and about two thirds receive public assistance and/or food stamps.

Half the mothers received WIC while pregnant, and nearly all plan to receive WIC postpartum. Overall, 15% of the mothers would like to receive more information on breast-feeding. About a quarter of the mothers live in public housing. While virtually all live in housing with complete kitchen and bathroom facilities, 18% report problems with their current living situation. Also, 13% feel they need a new place to live, and 9% feel they need help securing new living arrangements.

Overall, 20% of mothers feel they will need help finding a job or work training. This is one-third of the 56% who plan to return to work in the next year (not shown in table). Child care is another area where a substantial portion of mothers need help. A total of 40% of the mothers report needing help arranging child care to return to work or school.

Finally, to estimate mental health needs, the short form version of the RAND mental health measure was administered (McHorney & Ware, 1995). Using the cutoff suggested by RAND researchers, 95% of the mothers were classified as being in poor mental health. While some distress, anxiety, and depression could be attributable to pregnancy and delivery, this figure is still notable.

To some extent, these estimates of need may be conservative. It is expected that reporting bias has been minimized by efforts to distinguish the program and the evaluation from one another through both an intensive training of interviewers in neutrality in conducting the interview and through careful wording of items as well as interview and through careful wording of items as well as use of existing, validated instruments where possible. Even so, there is always the possibility that some mothers will give socially acceptable answers. In addition, it is possible that mothers use different norms in defining what they consider a problem, such as a problem with housing.

Family Characteristics

Twenty-nine percent of the families have a primary ethnic affiliation of Native Hawaiian, and 41% the families have any ethnic affiliation of Native Hawaiian (see Table 4). In 54% of the first 664 study families, the mother was a teenager at the birth of her first child. Almost half (48%) report domestic violence between the mother and father in the past year. P achieves statistical significance in two areas: ^{3} 3 episodes, father toward mother and ^{3} 3 episodes, either way. These numbers will continue to be monitored, and if need be, statistical adjustments will be made to compensate for this difference. Over half (53%) of the families reported problem alcohol use, and 48% reported problem use of other drugs. Sixty-eight percent of the families reported problem use of either alcohol or other drugs.

Discussion

As previously noted, there is strong endorsement for home visiting programs in general, and the HSP model in particular. Rapid proliferation of national and international replications of the Hawaii Healthy Start Program make this evaluation timely. The rigorous methodological safeguards against bias will enable home-based interventionists to have confidence in the study's findings at the conclusion of the evaluation. We are now in the midst of Year One outcome data collection and expect to begin reporting on program impact in late 1996.

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Evaluation of an Intensive In-home Services Program Aimed at Parents with Substance Abuse Issues Reported for Child Maltreatment

Authors

Introduction Method Results Discussion References

Introduction

Over the past decade, child protective services across the country have experienced an increase in reports of alleged child abuse and neglect. Researchers and others working in the child welfare field agree that one of the most important factors in skyrocketing protective services caseloads is an increase in parental substance dependence, particularly on crack cocaine (Curtis & McCullough, 1993). The Children's Defense Fund (1994) has found that parental substance abuse is a factor in 75% of foster home placements. Consequently, substance abuse and dependence has become the "dominant characteristic" in child welfare caseloads in twenty-two states and the District of Columbia (Besharov, 1989).

While there is widespread concern over the impact of parental substance dependence on the psychosocial development of children and the attendant risk of child maltreatment and family breakdown, little attention has been paid to developing and testing interventions to prevent family deterioration and negative child outcomes in families with a history of substance abuse. Few addictions treatment programs are aimed at the special needs of parents with alcohol and drug dependence who have children. Further, child welfare workers&endash;those most likely to come in contact with parents with substance abuse issues and have leverage to encourage treatment&endash;do not usually possess the knowledge or training required to intervene successfully with families that are drug involved.

In an effort to address the unmet needs of parents and children in families with substance abuse issues referred due to child maltreatment, a demonstration program was developed in one major metropolitan area to provide intensive in-home intervention with such families. Distal or outcome goals of the program were to: (1) prevent further child abuse or neglect, (2) prevent family breakdown and child placement, and (3) facilitate substance abuse treatment for caregivers. Proximal goals identified to enhance achievement of the outcome goals included: (a) increase parenting skills, (b) decrease levels of depression in substance-involved caregivers, and (c) enhance the cognitive and psychosocial development of children.

Method

Sample

Data were collected on 138 participating families referred to the program by the local public child welfare agency or from a hospital-sponsored drug treatment center that treated many parents living in the program's catchment area. Because of the location of the demonstration program in an impoverished, largely minority community, all participating parents or caregivers were African American, most were female, and 96% were receiving public assistance. Less than half of the participants were high school graduates.

Intervention

Prior research and clinical observation indicates that intensive emotional and concrete support can enhance the ability of parents with a history of substance abuse to seek and sustain addictions treatment (Nelson-Zlupko, Dore, & Kauffman, 1996). Maintenance of sobriety may result in improved parental mental health, thereby increasing the ability to engage in positive parenting, which, in turn, decreases child maltreatment and enhances child functioning.

Services provided in this demonstration program to help parents with a history of child maltreatment enter and sustain addictions treatment included: (1) in-home assessment, supportive counseling and referral by a substance abuse specialist; (2) linkages with substance abuse treatment programs; (3) developmental day care and respite for preschool children in referred families; (4) parenting education; (5) transportation; and (6) emergency funds, clothing, food, and other forms of concrete support.

Data collection

Data were collected from multiple sources including (a) clinician observation, (b) client self-report, (c) case record review, and (d) external reporters such as staff from drug treatment programs and the day care program. A mix of standardized instruments and project-developed survey forms were used. Standardized instruments included the following: (a) the Beck Depression Inventory (BDI), a widely-used measure of depression which was administered to the focal parent at three points in time; (b) the Adult-Adolescent Parenting Inventory (AAPI; Bavolek, 1984), a self-report inventory designed to identify inadequate and destructive parenting attitudes and behaviors; (c) the Denver Developmental Screening Test behaviors; (c) the Denver Developmental Screening Test (Frankenberg & Dodds, 1967), an observer rating scale of child developmental status; and (d) the Behavior Checklist for Infants and Children (BCIC; MacPhee, Benson, & Bullock, 1988), designed to measure caregivers' perceptions of children's social relationships, compliance, dependency, conduct, and activity level.

Goal attainment data were extracted from the Family Service Description, a document mandated by the public child welfare agency, completed at intake and containing case-specific treatment goals. Demographic data and substance abuse history were collected at intake using project-developed forms.

Results

Intake Description

Sixty-four percent of the parents in this study identified crack as their drug of choice. Twenty-eight percent identified alcohol, while smaller percentages reported marijuana or PCP as their drug of choice. As has been reported in other studies of women and substance abuse, the parents/caregivers in this study often used drugs in combination, particularly crack, alcohol, and marijuana.

At program intake, 67% of parents/caregivers were accepting of the need for substance abuse treatment; 5% were willing to consider treatment but not yet ready to accept a treatment referral; 10% actively refused treatment; another 18% were willing to participate in ongoing counseling or support around their need to accept treatment.

Treatment Completion

At three months post-program entry, the point of the first assessment of treatment progress, 43% of parents/caregivers were active in an addictions treatment program; 3% had completed addictions treatment and were still active in the demonstration program; 28% had dropped out of addictions treatment but were still active in the demonstration program; and, 18% had dropped out of addictions treatment and out of the program. At each data collection point in the study&endash;three, six, and twelve months post-treatment entry&endash;4 to 6% of clients who had completed addictions treatment were known to be substance-involved again, while another 21 to 31% who had dropped out of treatment were substance-involved.

Adjustment and Skill

The BDI confirmed what other studies of this population have found: there are high rates of depression among clients of minority status living in poverty who have a history of child maltreatment (Sachs & Hall, 1991). At program intake, less than half the parents/caregivers scored within the normal range on the BDI. Thirty-five percent scored the normal range on the BDI. Thirty-five percent scored within the range for mild depression; 11% showed mild-to-moderate depression, and 6% were moderately-to-severely depressed. At three months post-program entry, there was substantial, though not statistically significant, improvement on the BDI. Seventy-six percent of parents/caregivers scored within the normal range.

The AAPT, a measure of parenting behaviors, correlated highly with child maltreatment, between 38 and 48% of parents scored within the problem range on the four subscales of this instrument. These findings are consistent with other studies which have found that parents with a history of child abuse/neglect (a) often have unrealistically high behavior expectations for their children (Milner & Chilamkurti, 1991); (b) are less able to empathically understand their children (Belsky, 1993); (c) more often resort to physical punishment and punitive acts as control strategies (Whipple & Webster-Stratton, 1991); and (d) look to their children to meet their own unmet emotional needs. At three months post-intake, the percentages of parents scoring within the problem range on the four AAPI subscales were markedly lower.

The Denver Developmental Inventory (Denver II) and the BCIC were used to assess the psychosocial functioning of preschool children in participating families. Only those children who attended the developmental day care program were tested. At program entry, only 20% of children tested within normal developmental limits, 60% of the children's scores indicated below normal developmental functioning, and results for 20% of this group were questionable (i.e., exhibiting some developmental delays). By three months post-entry, 59% of children tested within normal limits on the Denver.

Parent Perspectives

On the BCIC, which measures parents' perceptions of their children's functioning, between 7 and 18% of children were viewed by parents as problematic depending on the dimension observed. For example, while only 7% of children were seen as exhibiting inappropriate dependency by parents, 18% were viewed as too aggressive, indicating behavior which may be more difficult for a single mother with drug problems to manage.

On the goal attainment scaling, agency caseworkers rated each family's progress on up to five problems addressed in treatment on a five-point Likert-type scale. At three months post-entry, 49% of problems addressed in treatment were slightly to much better; 51% were same or worse as at intake. By six months, these figures were 63% and 37% respectively; at twelve months, 73% and 27%.

Day Care Program Comparison

Families who participated in the day care component of the program (N = 71) had better outcomes than those who did not (N = 67). Sixty-five percent of parents/caregivers of children in the day care program completed addictions treatment as compared with just 16% of non-day care parents/caregivers ($p < .001$). Forty-one percent of day care families were discharged as meeting treatment goals compared to just 10% of non-day care families. In addition, children were removed to foster care from 34% of non-day care families as compared with 23% of day care families. However, these last two differences were not statistically significant.

Discussion

Findings from this study underscore the challenges of assisting parents who are at high risk for child maltreatment to accept and sustain addictions treatment. While the program was successful in encouraging a large number of parents/caregivers to enter substance abuse treatment, the treatment dropout rate was high, particularly among those who did not avail themselves of additional support from the day care program. On the other hand, 67% of participants either completed treatment, or dropped out and returned to treatment while participating in the demonstration program.

Current research indicates that many people with substance abuse issues, particularly women, experience several treatment episodes before maintaining sobriety. Participants in this demonstration program confirmed these findings. Sixty-nine percent had at least one prior experience in addictions treatment and a high percentage had two or more. Thus, even though 22% of clients (N = 30) entered and dropped out of treatment while participating in this demonstration program, these parents/caregivers are more likely to enter a treatment program in the future than those with no previous treatment experience.

Program success was not as apparent with regard to the goal of preventing family breakdown and preventing child placement. A child was eventually removed to out-of-home care for 28% of participating families (N = 30). There was a strong relationship between a parent or caregiver's refusal of substance abuse treatment and a child's removal from the home. It is not uncommon for an intensive intervention program such as this one to identify cases of child abuse or neglect that appear intractable to even the most focused and intensive intervention. That some parents/caregivers were offered an enhanced array of supports to facilitate addictions treatment, yet were unable to enter or sustain such treatment, suggests an unacceptable level of risk to children in the home. As has been demonstrated elsewhere, parent/caregiver addiction, particularly to crack-cocaine, is highly detrimental to parenting functions (Dore, Doris, & Wright, 1995).

The theory undergirding the enhanced supports offered parents with histories of substance abuse and child maltreatment in this demonstration program was that by increasing parenting skills, decreasing parent/caregiver depression, and enhancing the cognitive and psychosocial development of children, the incidence of future child maltreatment by participants could be reduced. As the review of findings indicates, there is evidence that parental attitudes and beliefs about both childrearing and levels of parent/caregiver depression improved over the first three months of active participation in the program. Results on the Denver II also suggest that, for those children who continued in the day care program over a three month period, there were significant developmental gains. This finding adds evidence that providing child care is crucial to enhancing both the probability that parents will seek and sustain drug treatment and promote developmental outcomes for their children. As current research has effectively demonstrated the interaction between child behavior and parent behavior in situations of child abuse, enhancing child functioning can only serve to decrease the risk of future maltreatment of these children.

In summary, findings with regard to effectiveness of this demonstration program cannot be stated with certainty because this was not a randomized study with a control group design. However, given what is known about treating the population represented by this sample of families with both substance abuse and child maltreatment issues, this program was successful in helping some participants make significant changes in their lives. There is no question that the families who participated in this demonstration program present with the most difficult problems facing families today. Poverty, lack of education and employment, substandard housing, and family and neighborhood violence, were present in addition to substance abuse for nearly all participating families. The mix of in-home counseling and support, linkages to addictions treatment, developmental day care, parenting education, transportation, and concrete services may be positive, effective combination in addressing the growing social problem of child maltreatment stemming from parental substance abuse.

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Effectiveness of Contracted Services in Individualizing and Tailoring Mentor Programming for Children with Severe Emotional Disturbance in a Public System

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Introduction

Recent research indicates that social support is an important factor in an individual's mental health and interpersonal adjustment (Frecknall & Luks, 1992; Queen, 1994). Traditionally, family and close friends served as social networks that provided the individual protection against stress or adversity. Adolescents who demonstrate positive adjustment to ongoing stress often identify a relative, friend, or neighbor as a natural mentor who contributed to their success (Rhodes, Contreras, & Mangelsdorf, 1994). Rhodes, Ebert, and Fischer (1992) have shown that a mentor relationship helps adolescent mothers experience less depression and feel less distressed by interpersonal difficulties. Based on such research, it seemed reasonable to hypothesize that mentor relationships could have a positive, therapeutic effect on children and adolescents at significant risk for out-of-home placement.

Belief in the integrity and healing capacity of the family unit coupled with the soaring cost of out-of-home placements has led Waukesha County, Wisconsin to develop creative, collaborative efforts to maintain troubled children in their homes. The Clinical Services Division of the Waukesha County Health and Human Services Department developed the Mentor Services Program in 1991 based on a community needs assessment that identified service gaps in the areas of social supports and respite care for children with severe emotional disturbance (SED). Developed as placement prevention, Mentor Services expand the array of clinical treatment resources and community-based care received by the child and family and can be tailored to individual needs. The program is delivered through a services contract with the outreach department of a residential treatment center. The center staff recruit and hire mentors in part-time positions, matching the training, skills, and availability of the mentor to the specific needs and strengths of the participating child and family.

Mentors provide regular, consistent, face-to-face and telephone contact with children who have severe emotional disturbance. Mentoring is part of a coordinated team treatment effort to maintain and support children in their home communities by strengthening their family relationships and by facilitating their successful integration into existing community resources.

Mentors provide support and respite care for children and their parents through monitoring and supervision of the child's functioning in various settings, both recreational and educational (e.g., modeling and coaching of various social skills including sharing, sportsmanship, and anger control techniques; supportive counseling and utilization of child behavior management strategies; and assistance to families in child/parent conflict resolution). When appropriate and necessary, mentors provide assistance to schools by monitoring and addressing barriers to school success. Mentors provide verbal reports at least weekly to the referring worker and attend treatment team meetings to evaluate the child's progress. A written record of all contacts with the child/family is maintained, and a monthly summary is prepared regarding the therapeutic connections between the activities and the ongoing treatment goals.

Method and Results

In this study thirty children meeting SED criteria and considered to be at extreme risk for out-of-home placement were enrolled in the mentor service for five hours each per week. All children carried a DSM-IV psychiatric diagnosis (American Psychiatric Association, 1994), and according to county criteria for placement, would have been expected to be placed in an out-of-home setting within six months of their original SED staffing. Sample demographics are contained in Table 1. Of the 30 children discharged from the program during 1991-95, 22 remained in their family home six months post discharge. Five of the children had been placed into residential treatment and three had moved from Waukesha County's jurisdiction. This placement rate of 18.5% is significantly less than the placement rate experienced by a control group of ten children who were referred for mentoring service but not served. The placement rate for the control group was 50% within six months of referral.

The average monthly cost for all treatment intervention with the mentored children was approximately $2,300 per month, with mentor costs of about $430 per month. This compares to an average cost of approximately $4,500 per month for residential care and in excess of $10,700 per month for a State mental health institution (see Figure 1).

Parents completed 7-point Likert-type scales on nine parameters designed to measure program effectiveness in reducing home, school, and community problems. Parents reducing home, school, and community problems. Parents also completed ten scales designed to measure their satisfaction with program characteristics such as child/mentor match, length of service, and respite (see Figure 2). The results suggest that families viewed mentor services as an integral and effective component of the treatment process. Parental ratings indicate that mentoring had the largest initial impact on problems and conflicts within the home. Overall, changes associated with mentoring services were relatively stable over the six months following discharge from the program. Scale values for acting out behavior (e.g., alcohol or drug abuse truancy, legal problems, etc.) showed the least deterioration over the six month span. Parents also rated the program highly as a respite service for family members, including the child.

Discussion

Placement data suggest that mentoring can be a highly effective clinical tool for certain populations of at-risk children. Results show that clinical mentoring may be more effective when the child carries a diagnosis of a disruptive behavior disorder compared with those children diagnosed with an affective disorder such as major depression. This may be because the major affective disturbances disrupt the child's ability to relate socially and form meaningful interpersonal relationships. The ability to form such relationships is believed to be the foundation of therapeutic mentoring. This review also indicates that mentoring is less successful with children under the age of 12 or 13, possibly because younger children have developmentally less sophisticated interpersonal skills and have more difficulty forming a social/therapeutic relationship.

When compared to the control group of non-mentored children, mentored children were significantly less likely to be placed in a child caring institution, such as a residential treatment center, group home, or treatment foster care. Mentoring was also an extremely cost effective component of overall treatment for at-risk children when compared to those more traditional treatment venues (see Figure 1). Families consistently rated mentoring as an integral and crucial resource in the individualization and tailoring of a collaborative plan of care among home, school, and community services. Lastly, families continually emphasized the importance and value of the respite inherent in ongoing mentor services.

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Treatment Outcome in a Community Based Children's Outpatient Mental Health Clinic: Pre-Managed Care

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Introduction

The majority of treatment outcome studies in outpatient children's mental health services have taken place in research clinics. Findings from research studies have been consistently positive. In contrast, there exist only a handful of published outcome studies based in "naturalistic" settings with mixed and far less positive results; Weisz and Weiss (1993) address this problem with the "good news bad news joke" which states that "the good news is that child psychotherapy works; the bad news is, not in real life" (p. 96).

Contrasting procedures between research and "real world" clinics may explain these observed differences in treatment outcome. Werry and Andrews (1996) point out that "there is little resemblance between what researchers study and what practitioners do" (p. 879). Differences in procedures between the research and naturalistic settings include the following: subject recruitment, parental involvement in treatment, stringent treatment protocols, exclusionary criteria, manualized treatment, and completion of measures by both therapists and patients (Kazdin, 1991; Kendall & Southam-Gerow, 1995). Such procedures are often an anathema to both clients and clinicians in naturalistic settings and likely result in different clinicians treating and different subject populations being seen at research versus non-research based clinics.

In the adult literature, Seligman (1995) describes this dialectic by distinguishing between "efficacy" studies in research clinics and "effectiveness" studies in "naturalistic" settings. Under tightly controlled conditions with sophisticated methodology, efficacy studies conducted in research clinics differ from effectiveness studies which assess "how patients fare under the actual conditions of treatment in the field" (Seligman, 1995, p. 966). Although both approaches contribute to our knowledge of treatment outcome, "effectiveness" studies may hold the greatest potential to teach us about the majority of clients and clinicians who participate in the "real world" of mental health. Seligman (1995) further extends this contention by asserting that "the efficacy study is the wrong method for empirically validating psychotherapy as it is actually done" (p. 966). However, a number of investigators in children's mental health have proposed research methods to close this chasm. They have underscored the need to examine ways to improve the transition from efficacy research to effectiveness research (Clark, 1995), increase the transportability of research based treatment to naturalistic settings (Kendall & Southam-Gerow, 1995), and bridge the gap between laboratory/university and clinic/community based treatment (Henggeler, Schoenwald, & Pickrel, 1995; Hoagwood, Hibbs, Brent, & Jensen, 1995; Weisz, Donenberg, Han, & Weiss, 1995).

The present study was designed to contribute to the scant literature on outcome data derived from naturalistic settings. It was hypothesized that children would demonstrate reliable and positive improvement from pre- to post-treatment based on standard parent and therapist outcome measures. Specifically, parent rated improvement of their children's internalizing and externalizing symptoms on the Child Behavior Checklist (CBCL; Achenbach & Edelbrock, 1983) and therapist rated improvement on both the Global Assessment of Functioning (GAF; Diagnostic and Statistical Manual of Mental Disorders, 1987) and the Children's Global Assessment Scale (CGAS; Shaffer et al., 1983) were expected. Furthermore, given an emphasis in treatment on parent involvement, it was hypothesized that families would report higher levels of family cohesion and organization, less family conflict, and a greater sense of community involvement (e.g., recreation) as assessed by the subscales of the Family Environment Scale (FES; Moos & Moos, 1986).

Method

Subjects

Parents and clinicians of fifty-one children (N = 51; 32 boys/19 girls), receiving between 16 and 90 therapy sessions, completed measures before initiation of treatment and at termination. All cases represent agreed-upon discharge between the family and therapist. Demographic variables are presented in Table 1. This sample represents a fraction (less than 5%) of the clinic population over a 5-year period (1989-1994) and contains an over- representation of Caucasian children (80%), cases that were self-referred (94%), and cases with significantly more treatment sessions (M = 43) in comparison to our general clinic population. During the time period that this data was collected, Caucasian children represented 40% of the clinic, only 20% of the children were self-referred, and cases were seen an average of 24 sessions. However, the current subject sample did not differ from the general clinic pool from which it came in age, gender, caretaker status (one parent versus two parent), residence (urban versus suburban), socioeconomic status as measured by the Hollingshead (1975) Five-factor Index of Social Status, or pay source (insurance versus medicaid).

Measures

The parent rated CBCL includes 118 items on a 0-2 point scale which rate a variety of behavior problems and yields an internalizing, externalizing, and total score composite. The FES includes 90 true-false items about family functioning across 10 subscales (i.e., conflict, cohesion, expressiveness, independence, achievement, intellect, religious, recreation, organization, & control). The GAF measures overall adaptive functioning and is rated by clinicians on a 100 point scale (higher scores indicate better functioning). Similarly, the CGAS is rated by clinicians on a 100 point scale and measures the child's lowest level of functioning within the past week (higher scores indicate better functioning).

Procedures

All clients were seen in the Outpatient Clinic of the Yale Child Study Center. The clinic's orientation is primarily long-term, psychodynamic treatment. Prior to clinic contact, parents completed both the CBCL and FES; these two measures were also completed by parents at discharge. The treating clinician rated the child on the GAF and CGAS at evaluation and discharge.

Results

Main Analyses

To test our general hypothesis that children would improve as a result of therapy, we ran paired sample t-tests on our primary criterion measures of interest (i.e., the parent completed CBCL and FES scales and the clinician rated GAF and CGAS). In order to control for chance findings, we used the conservative Bonferonni correction and required a value of p = .006 (i.e., .05/8) to consider our findings significant. At this adjusted alpha level, significant improvement was reported on the CBCL (internalizing, externalizing, and total scales), the CGAS, and GAF. In addition, there was a significant increase in the "Recreation" and "Organization" subscales of the FES (see Table 2). There was no significant change from pre- to post-treatment on the "Conflict" and "Cohesion" subscales of the FES.

Discussion

Fifty-one children receiving long term dynamically oriented therapy at a "real world" clinic improved in their functioning as rated by parents and clinicians. In addition, parents reported improved family management practices and a decrease in social isolation from the beginning to end of treatment. These parallel gains in child and family functioning address the interactions between child and family well-being and are consistent with prior research (Armbruster, Dobuler, Fischer, & Grigsby, 1996).

Despite these positive results, the validity of our findings is limited by a number of factors. First, without a control group it is difficult to attribute improvement to the intervention or to natural maturational processes. The effect of maturation is particularly relevant in view of an average treatment duration of nearly a year. Second, although the sample was similar to the general clinic population in age, gender, caretaker status, residence, pay source, and SES, it differed in that it was comprised primarily of Caucasian, self-referred, long term therapy cases. Finally, only families who were discharged from treatment by mutual agreement between therapist and client and completed the post measures were included in the study. Excluded were those families who dropped out of treatment or were discharged but who did not complete the post measures. Follow-up for these families was beyond the scope of this study.

These limitations may be understood in a number of ways. The preponderance of Caucasian families in this study may point to the issue of cultural congruity between therapist and client (Armbruster & Kazdin, 1994). Studies have shown that similar ethnicity/race of clinician and client predict continuance in therapy (Cheung & Snowden, 1990; Flaskerud, 1986). At the time of this study, there was a significant lack of minority therapists at the clinic which may have interfered with African American families forming positive alliances with their therapists. The group for which pre- and post- measures were collected may reflect a "goodness of fit" (Chess & Thomas, 1986) between family and therapist. This "fit" may be partially accounted for by compatible levels of motivation, accountability and commitment, as well as similar racial/ethnic characteristics. The motivational factor is further supported by the fact that the majority (94%) of families were self-referred.

In this study, self-selection bias in clinician and parent may lead us to conclude that treatment is effective, when in fact, we have sampled only a small percentage of highly motivated parents and clinicians. This study underscores difficulties inherent in evaluating effectiveness in "naturalistic" settings where clinicians are less motivated to adhere to research designs, especially those involving the administration of post measures (Henggeler et al., 1995; Hoagwood et al., 1995; Kazdin, 1991). The advent of managed care with its requirements for accountability (e.g., treatment outcome data) may provide the opportunity to conduct research in "naturalistic" settings with a more representative sample. In addition, managed care will undoubtedly restrict the length of treatment and reduce the likelihood that improvement is due solely to maturational effects. Future studies will be able to improvement is due solely to maturational effects. Future studies will be able to examine populations within this modified framework.

In summary, "naturalistic" (Weisz & Weiss, 1993) or "real world" (Jensen, Bloedau, & Davis, 1990) child outpatient mental health clinics represent the majority of mental health services provided to children. Our findings suggest that reliable and positive results can be achieved for those families and therapists in "real world" clinics who remain committed and accountable to the therapeutic process. Although this is an initial study with limitations, it offers an optimistic glimpse into the outcomes achieved by "treatment as usual."

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Lessons Learned From The Fort Bragg Demonstration

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Introduction

The Fort Bragg demonstration provided a comprehensive approach to the delivery of mental health and substance abuse services to a population of approximately 48,000 (FY95) military-related children under 18 years of age who resided within the Fort Bragg catchment area. A major purpose of the project was to study the implications of expanding the health care benefit package provided to military families through the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) by providing a full continuum of mental health and substance abuse services (Bickman et al., 1995).

As an experiment in systems change, the Fort Bragg demonstration yields a wealth of valuable "lessons learned" for policymakers, practitioners, researchers, and consumers. These lessons have implications both for those involved in children's systems reform efforts, as well as those undertaking managed care initiatives affecting children and their families.

Method

Over the last six months of the demonstration, over two hundred individuals were interviewed, including administrators, clinicians, families, policymakers, and other stakeholders, who had been involved in the Fort Bragg project since its inception. Interviews were conducted by a team of independent policymakers, researchers, family members, and clinicians, all of whom have been involved in national and state systems reform issues over the last decade. The team also reviewed the extensive written documentation available from the demonstration, the formal evaluation conducted by Vanderbilt University, and client characteristic and service data over the life of the project.

What Fort Bragg Was and Was Not

Through the study, there emerged greater clarity as to what the Fort Bragg demonstration was and was not.

Fort Bragg was not managed care. The demonstration sought specifically to increase access and utilization without particular regard to cost, in contrast to managed care, which is concerned fundamentally with controlling cost by managing access and utilization. There was no risk attached to management and service contracts (which were cost-reimbursable); many incentives existed, on both the supply and demand side, to provide and use services.

The demonstration also was not a system of care; that is, it was not an integrated continuum of mental health and related services and supports in which there is shared "ownership" of the system across multiple child-serving systems (i.e., education, child welfare, juvenile justice and mental health).

Fort Bragg was not a continuum for "high end users" (i.e., children with serious disorders, only). Nearly 60% of the evaluation sample received no service more intensive than outpatient.

Fort Bragg was a demonstration of a community-based continuum of mental health and substance abuse services, with a single point of access, for a total child/adolescent eligible population (i.e., for both acute and extended care populations and for children with both mild and serious disorders). It changed an existing, poorly regarded system, as it intended; it expanded the array of services, eliminated co-pays and deductibles, reduced use of inpatient and residential treatment, increased access and utilization, and was held in generally high regard by families and the larger community. With this success, however, there emerged countervailing pressures and issues (e.g., cost pressures, overutilization of multiple services, unrealistic expectations on the part of some families and clinicians, and apparent cost shifting to and from the demonstration). To its credit, the demonstration made every effort to be a self-correcting the demonstration made every effort to be a self-correcting experiment.

Critical Lessons Learned

Service Utilization

At least two important lessons emerge from looking at the greatly expanded service utilization created by the demonstration. The first is the "if you build it, they will come" lesson. If mental health services are offered to families in ways that are accessible, stigma-reducing, and individualized, they will be used&endash;and probably more heavily than a developing system can accommodate without creating problems in other areas, such as cost problems, inadequate provider training, inadequate monitoring, and quality assurance. A response to these problems is not necessarily to restrict access, which remains a worthwhile policy goal, but rather to design the demonstration and manage services during implementation in ways that promote more deliberative start-up and efficient treatment.

A second lesson from looking at service utilization in Fort Bragg is the importance of analyzing as accurately as possible the population eligible for services prior to implementation (i.e., who and how many can be expected to use services). This requires striking some balance between using prior utilization and prevalence data. The Fort Bragg demonstration was hampered by the inadequacy of the Army's data regarding how many children were using services and the types of services being used, as well as the insistence to base expected use on prior utilization only. There is a particular lesson here for managed care initiatives which have a tendency to rely on prior utilization to develop capitation rates. The Fort Bragg project suggests strongly that use of prior utilization alone will be an inaccurate predictor if it is applied to a more attractive, accessible, community-based continuum of behavioral health services.

Fort Bragg points to the need for individualized system planning for different subclusters of children in a total eligible population. For example, while "high end" users may need intensive case management and treatment planning, this is clearly not the case for children using only outpatient services. Children involved in other public systems, particularly child welfare, will require more time on the part of clinicians to manage the boundaries between the systems and deal with the requirements of the other system. Children with ADHD may require less intensive involvement with mental health but greater collaboration with the pediatric services. Fort Bragg suggests an important lesson about the need to desegregate the eligible population into types of users and institute approaches that make sense for different subpopulations&endash;the "not every child needs the same system" lesson.

Cost

Perhaps the most important cost-related lesson from Fort Bragg is that of linking cost and quality issues in design and implementation&endash;a lesson which Fort Bragg itself learned, somewhat painfully, and took steps to change. It is not possible to maintain quality of care without paying attention to cost; clinical viability alone is not sufficient. Inevitably, costs will run high if not attended to from the outset, leading to enormous pressures for cost containment that then can jeopardize quality of care. Cost containment pressures, in turn, will aggravate tendencies of cost-shifting to other child-serving systems.

A related cost lesson is the importance of thinking through in advance the effect on supply and demand of the incentives that are built into the system for providers and consumers to provide and use services, respectively. To its credit, Fort Bragg took a number of steps by the latter half of the demonstration (post the evaluation phase) to modulate some of these incentives and control costs without necessarily jeopardizing quality of care. It also instituted greater efficiencies in service delivery through the following: (a) streamlining its intake process; (b) emphasizing shorter-term, problem solving therapies; (c) adhering more closely to level of care criteria; (d) instituting guidelines for use of psychiatrists; (e) streamlining its case management process; and (f) streamlining the treatment planning process. It created more structured utilization review, with a clearer focus on length of stay, and imposed a more integrated focus on cost, quality, and service issues through its quality improvement process with feedback loops to service providers about both cost and quality. In this process, the demonstration also had to begin to clarify its own values about cost and quality issues&endash;again, an important lesson. When cost containment values were introduced into the service system late in the demonstration, there was indeed a dramatic reduction in the cost of providing treatment.

A strong argument can be made from the Fort Bragg experience that research and development costs and costs associated with requirements imposed by demonstration sponsors should be budgeted and tracked separately from the costs associated with service delivery. Fort Bragg also suggests (as do many other demonstrations in the children's arena) that the time normally accorded to systems change efforts (typically, three to five years) is simply too short to preclude inefficiencies in start-up, development, and modification of new approaches (Friedman, 1996).

A final cost lesson from Fort Bragg relates to the possibility that greater efficiencies may very well have been achieved, at least with respect to Fort Bragg children involved in multiple systems, had the demonstration actually implemented a system of care with shared ownership across the major child-serving systems, instead of a continuum of mental health services "owned" by the Army. Certain inefficiencies occurred because separate systems prevailed.

inefficiencies occurred because separate systems prevailed.

Service Delivery

A great many lessons can be drawn from the demonstration about effective service delivery.

Regarding intake and assessment:

- Intake staff need access to an array of crisis options;
- intermediate-level services, particularly in-home services, need to be available from the outset to prevent inappropriate hospitalization and residential care;
- an intake process that focuses on presenting problems, using a problem list, rather than on "nailing a diagnosis" is needed to promote efficiency;
- small co-pays are needed to prevent an initial recurring problem of missed appointments; and
- intake staff need to be trained well in the treatment philosophy and goals of the demonstration, how the service system is organized, and the resources available to them.

Regarding the treatment team process:

- It is critical to make the treatment team responsible for managing/monitoring length of stay and appropriateness of care to better link treatment and cost concerns;
- a multidisciplinary treatment team does not have to be held for every child entering the system but should be reserved for children with serious or complex disorders;
- the more people who are involved in the treatment team process, the more time-consuming and expensive it will be (i.e, multiple players on the treatment team may aggravate the problem of overuse of multiple services, since each player has a tendency to become an advocate for the service he or she is representing, which also drives up costs);
- an effective treatment team process is one governed by tight clinical leadership and a better understanding of how the various levels of care relate to one another;
- much more needs to be learned about what service components work best for which types of children over what period of time; and
- it is important to be creative in treatment planning and not allow a child to stay in an inappropriate level of care simply because the needed service is unavailable.

Quality Improvement

A number of lessons can be drawn about quality improvement (QI). The QI program should be developed with the involvement of staff and providers, as well as families, and incorporate peer review to create ownership and "buy-in." QI should provide information to clinicians and "buy-in." QI should provide information to clinicians concurrently with service provision, not retrospectively, so that feedback in areas such as length of stay and family satisfaction gets to providers in a timely fashion, not after the fact. QI should track more than cost and utilization; it needs also to track systems outcomes across the continuum, client outcomes, and family and youth satisfaction. QI and utilization review functions need to be integrated. QI data needs to be tied to credentialling of providers. It is unrealistic to expect a full-blown QI program to be in place before clinical services are fully developed. Implementation of an effective QI program is a developmental process that requires time.

Staff and Provider Network

One of the lessons of Fort Bragg is the importance of orienting the staff and provider network to the values and goals of the demonstration and of evaluating staff and providers against the demonstration's desired outcomes. Because differing values are inevitable among staff and providers, it is essential to articulate clearly the demonstration's values as a unifying element and to create an in-house process to air and resolve differing values. Without such a process, staff become polarized around different philosophies, instead of working synergistically.

Family Involvement

Perhaps the most salient lesson about family involvement is the danger in assuming that everyone means the same thing by "family involvement," the importance of articulating clearly what the demonstration means by it and the importance of training staff in the demonstration's philosophy and service approach to families. There needs to be clinical leadership to help families make good decisions. Lack of strong clinical leadership, particularly at a systems level, affects cost. In the absence of such leadership, there is a tendency for staff and providers to overload families with services and for families to become dependent, aggravating lengths of stay and therefore cost.

Environmental Context

Systems change experiments in the children's arena operate in complex political, social, and interagency environments. Particularly in the children's arena, changes in one system will affect all other child-serving systems.

Fort Bragg reinforces the usefulness of environmental and ethnographic analysis for anticipating how services will be used and for informing deliberations about optimal treatment approaches for the target population. For example, it might be anticipated that ready access would be a major factor in the willingness of Army families to use services because of the Army mentality of "do it now." Similarly, the location of services off-base might also have been anticipated to increase demand for services because of the preference of military families to use non-base providers, particularly for mental health services where stigma is an issue. The transiency of the military family, particularly those at this rapid deployment base, might have argued in the design phase for shorter-term, problem-solving treatment approaches and shorter lengths of stay. The rapid deployment nature of the base, which has the effect of depleting medical staff from the base, might also have been anticipated to result in some patient-shifting from the Army medical center on-base to the demonstration, as indeed occurred.

Evaluation

Just as it is essential for demonstration implementers to be clear about their purpose, it is critical that evaluators are careful to define clearly what it is they are evaluating. It also is critical that appropriate caveats be included regarding comparison sites that are used. Typically, there are political, operational, and other constraints that influence the choice of comparison sites, which necessarily affects comparability. Those involved in the demonstration believe that the most, perhaps only, comparable site to Fort Bragg is Fort Hood, which, for a number of reasons, could not be used (L. Behar, personal communication, Summer, 1995). Both bases, unlike the comparison sites that were used, are involved in rapid deployment, house specialized forces, have large pediatric populations, have high birth rates, and have a large concentration of low income military personnel. It is possible that these factors create more difficult-to-treat mental health problems. If this is the case, then the fact that Fort Bragg had outcomes as good as, and in some cases, better than the comparison sites that were used, is encouraging. Similarly, a caveat might have been noted regarding the potential influence on outcomes of co-pays and deductibles, with which families at the comparison sites, but not Fort Bragg families, had to contend. Families at the comparison sites may have been more motivated, due to the presence of co-pays and deductibles, to use services and to use them more efficiently. This motivation, in turn, may have helped to produce better treatment outcomes.

In assessing adequacy of implementation, evaluators need to be clear about the stage of implementation that is being evaluated, as systems change experiments are highly developmental in nature. They also need to define carefully what aspects of implementation are being assessed and the limitations of those aspects to creating a holistic picture of implementation. The Fort Bragg evaluation, for example, evaluated case management and intermediate services as indicators of adequacy of implementation. The evaluation did not assess the appropriateness of case management for the various populations of children receiving that service, which proved to be an issue. The evaluators assessed intermediate services in one clump, rather than separately, making it impossible to determine whether certain components were more or less well developed than others, which might affect results. Also, at the time of the implementation evaluation, the demonstration was at a relatively early stage of development, besieged by a heavy demand for services, an influx of new providers, and without well developed internal management and control, quality assurance and utilization review mechanisms, all of which affected results.

Evaluators need to be very careful in their interpretation of cost findings. In Fort Bragg, one might have concluded that the high costs associated with the demonstration were exactly what might have been anticipated given its design. This is a quite different interpretation than saying that costs were higher than expected. This goes back to the earlier point about the importance of both the demonstration and the evaluation being clear about purpose and goals.

Summary

Demonstrations are expected to undertake many new endeavors very quickly. Fort Bragg, for example, had to simultaneously educate the community, hire new staff, contract with outside providers, start new programs, build internal management and monitoring mechanisms, respond to sponsor demands for information and adjustments, orient and train new staff and providers, find facilities, etc. Multi-faceted systems, changing experiments in the children's arena, need time and a deliberately phased timetable, with benchmarks along the way, to be implemented (and evaluated) effectively.

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Children's Mental Health in a Continuum of Care: Clinical Outcomes at 18 Months for the Fort Bragg Demonstration

Authors

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Introduction

In the face of the seriously fragmented state of children's mental health services in the United States (Knitzer, 1982), Stroul and Friedman (1986) proposed that children receive services in a service system focused around a mental health continuum of care that would be comprehensive, community based, family focused, and culturally competent, providing services in the least restrictive setting possible. The continuum of care is a full range of mental health services that includes residential, intermediate, and nonresidential services. The assumption behind the continuum of care is that children would improve more under a continuum, because they would receive more appropriate, individuated services (Bickman, 1996a). To date, only one study, the Fort Bragg Evaluation Project (FBEP; Bickman et al., 1995), has conducted an empirical test of this assumption. The FBEP found no differences after one year in clinical outcomes between children treated in the continuum of mental health services of the Fort Bragg Child and Adolescent Mental Health Demonstration Project in Fayetteville, North Carolina (the Demonstration)[1] and children who received traditional CHAMPUS[2] services at two comparison sites (the Comparison), although clients improved at both sites. This led the evaluation team to conclude that the continuum of care theory was not supported.

This conclusion, however, has been disputed (Behar, 1996; Friedman & Burns, 1996; Lane, 1996). Although these disputes have been addressed (Bickman, 1996b), perhaps longer term follow-up may show that the Demonstration was more effective and successful for children with SED (Friedman & Burns, 1996). This paper uses data collected by the FBEP at 18 months (Wave 4) to do so.

The Demonstration and the FBEP

Although the Demonstration and the FBEP have been described in detail elsewhere (Bickman et al., 1995), they are briefly reviewed here. The Demonstration provided a continuum of mental health services, including outpatient therapy, day-treatment, in-home counseling, therapeutic homes, specialized group homes, 24-hour crisis management services, and acute hospitalization. Individual case managers and interdisciplinary treatment teams worked with all children assigned to outpatient therapy in order to integrate and fit services to the needs of each child. Treatment plans utilized the least restrictive service options, and services were community-based. No co-payments were required for children and their families.

The FBEP, a quasi-experimental study, collected mental health outcome data on 984 children, ages five to 17, and their families to evaluate the relative effectiveness of the Demonstration. Five hundred and seventy-four children received mental health services at the Demonstration site. The remainder received mental health services at two comparable Army installations, Fort Campbell and Fort Stewart. Children at these sites received CHAMPUS services. Data collection occurred within 30 days of entry into the service system (Wave 1), six months (Wave 2), 12 months (Wave 3), and 18 months (Wave 4) after a participant's entry into the study. The data includes structured diagnostic interviews, behavioral checklists, demographic data, and other relevant background information. The children and adolescents at both the Demonstration and Comparison sites were comparable at intake on background, demographic, and initial mental health status (Bickman, et al., 1995). Children were predominantly male (63%), white (71%), and were mostly from middle income (54% earned between $20,000 and $40,000) two parent families (80%) in which at least one parent had some higher education (87% of families had one parent with more than a high school education). The average age was 11 years.

Methods

Twelve key outcome variables for Wave 4 (18 months) were analyzed using a random regression (Gibbons et al., 1993; Laird & Ware, 1982) or a hierarchical linear model (HLM; Bryk, Raudenbush, & Congdon, 1994; Bryk & Raudenbush, 1992). These variables, summarized in Table 1, are the same key variables used in earlier analyses (Bickman et al., 1995), except that the Global Level of Functioning (GLOF), an adaptation of the Child Global Assessment Scale (Shaffer et al., 1983), was dropped because it is redundant with the Child and Adolescent Functional Assessment Scale (CAFAS: Hodges, 1995), and the Vanderbilt Functioning Inventory (VFI; Bickman, Lambert, Summerfelt, & Karver, 1996), a short checklist of obvious functioning problems, was added.

Random regression or HLM overcome problems measuring change inherent in classical models, such as measuring change as a two-wave difference score versus a covariance residual or deleting whole cases missing any data versus imputing data not observed. Random regression and HLM use all observations and measure time exactly. Subjects are treated in these analyses as a random effect. Groups and explanatory covariates are treated as fixed effects. If the Demonstration children improved more, they would exhibit a significantly steeper slope than the Comparison children.

Because the FBEP had a serious amount of attrition (i.e., completion rates over 4 waves for the 12 key variables ranged from 65% for the grand total pathology measure to 81% for the VFI), and because attrition rates varied significantly between sites for several measures (i.e., participants from the Demonstration had higher attrition on the CBCL, the YSR, and the VFI), an attrition analysis was performed to determine whether attrition influenced differences in rates of clinical change by site. Two random coefficients outcomes analyses were conducted for the 12 key variables with "missingness" added in. "Missingness" was first defined categorically as missing either one or more waves or missing none, and then as the number of missing waves. If "missingness" influenced results, then there would be significant wave by site "missingness" effects.

In each approach, only one result was significant (the VFI in the unbalanced analysis, the Most Intense Child Reported Psychopathology in the balanced analysis; $p < 0.05$). Because only one of 12 results was significant, and the two different approaches show significant results for different outcome variables, it can be concluded that the influence of missing data on the outcome analyses was negligible.

Results

The belief that the Demonstration would result in improved outcomes for children over time is not born out by the mental health measures at 18 months for the entire FBEP mental health measures at 18 months for the entire FBEP sample. Only two of the 12 key variables, the CAFAS and the VFI (both measures of functioning) showed significant site differences, and these results contradicted each other (see Table 2). According to the CAFAS, children at the Demonstration site were functioning better at 18 months, while according to the VFI, children at the Comparison site functioned better.

When the same analyses are restricted to the 317 children with serious emotional disorders (children with any PCAS diagnosis at intake and a GLOF score < 61), the picture changes slightly (see Table 3). The same contradictory results are found for the CAFAS and the VFI, yet the Demonstration is more effective according to the YSR.

Conclusions

The claims that services in the Fort Bragg Demonstration's continuum of care will be proven more effective than a traditional fee-for-service system of care over a longer period of time and that the Demonstration was effective for children with SED were not supported. At 18 months, only one of 12 key mental health outcome variables (CAFAS) favored the Demonstration for all children in the study, and that finding was contradicted by results from the VFI that favored the Comparison. For children with SED, only two outcomes favored the Demonstration (CAFAS and YSR) while the VFI again favored the Comparison. Even if the results for the VFI are discounted because its reliability and validity have not yet been established, the Demonstration still does not appear substantively more effective. Even when looking only at children with SED, the fact that only two of the twelve outcome variables favor the Demonstration at 18 months suggests that the continuum of care at the Demonstration site did not result in relative greater improvement.

It is clear from this data that the earlier conclusions from the FBEP are supported by the 18 month findings. Children at both sites improved equally, and the idea that a continuum of care yields better mental health outcomes remains unsupported. Also, given the Demonstration has not proven more effective over the 18 months, there is little rationale to expect that a Demonstration effect will become evident even further down the line. In light of these findings, researchers and policy makers need to reconsider the continuum of care. If a continuum of care can be implemented in a more cost efficient manner than it was at Fort Bragg, it is possible that the benefits of the Demonstration that were shown (i.e., increased access to more coordinated, individual, and less restrictive care community based services without a loss in the quality of care) will be considered adequate to justify implementing continuums of care for children's mental health services elsewhere.

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New Jersey's Program for Youth with Special Emotional Needs: How Well is it Working?

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Introduction

In August, 1991, the Youth Incentive Program (YIP), was officially launched in New Jersey. The program, which represented a major restructuring of children's mental health services, grew out of earlier private and public efforts and reflected national trends in the reform of mental health services for children. Cutting across most of these programs is the underlying principle that home-based, family-centered care within an integrated cross-system interagency structure will best serve troubled children and adolescents.

As initially set up, the YIP consisted of an administrative unit and service team in each of the 21 counties of New Jersey. The administrative structure, the County Interagency Coordinating Council (CIACC), was created for the purpose of establishing policies and structures to increase coordination and monitor interagency services. The service units, called the Case Assessment Resource Teams (CARTs), were multi-disciplinary teams charged with making a comprehensive assessment of the target youth and family and the development and follow-up of multi-system treatment plans. The priority target population was children and youth with special emotional needs in the child welfare, juvenile justice and mental health systems, who were at risk of institutional care.

Method

Two years after its inception, a state funded process evaluation was undertaken to determine the degree to which the program was achieving its key goals. The evaluation utilized data gathered through surveys as well as statistics and information collected for administrative purposes by the state. Three different surveys were utilized: (a) a self-administered questionnaire completed by the 21 CART Coordinators in the state; (b) a telephone interview completed by 97 out of 107 sampled CART members from the 27 state CARTs; and (c) in-person interviews with 38 parents randomly selected from four geographic regions of the state, and 28 of their adolescent children.

Six major research questions addressing critical aspects of the service system model guided the evaluation:

- To what extent was the identified target population being served?
- To what extent did the system of care represent a multi-discipline, multi-system approach to delivering comprehensive integrated services to youth and their families?
- To what extent did CART members, parents, and children believe that the CARTs facilitated the active involvement of parents and youth in service planning?
- To what degree did parents and children actually participate in service planning?
- To what extent were services comprehensive, non-traditional and family-centered as well as child-focused?
- How helpful was the program to the children and their families?

Results

The children who were served (ranging from 8 to 18 years of age) clearly met the criteria for the target population. They came from the child welfare, juvenile justice, and/or mental health systems and were at risk of residential placement. Nearly all the children (97.3%) had previously been placed out of the home or were hospitalized. They had an extensive history of serious emotional disorders. Seventy-five percent had been hospitalized for a psychiatric illness. The mean age of first placement was nearly 11 years of age. On average, the child was eight when the parent first became aware that the child had a problem. Over 80% of the children had taken medication for an emotional problem.

One important program goal was to provide a structure that was multi-system and multi-discipline to provide integrated services. Our indicators showed that, indeed, the CART membership represented a broad spectrum of disciplines from diverse community providers. CART members listed more than ten areas of professional training, with the following four disciplines identified by over 80% of the following four disciplines identified by over 80% of the respondents: social work, psychology, educational counseling, and corrections. All CARTs were comprised or representatives of three community service systems&endash;mental health, child protective services, and youth services (shelter, detention, probation, family court, etc.). Two-thirds or more of the CART teams also had client/parent advocates, children's clinical case managers, representatives of the educational system (usually child study team staff), and professionals from a broad range of other community based agencies (e.g., companionship programs, substance abuse programs, and programs for the prevention of child abuse and neglect).

These providers worked well together and CART members rated their teams in terms of five factors pertinent to the quality of working together: 1) the team members' training, experience and philosophy, 2) members' understanding of the CART mission, 3) members' acceptance of the CART mission, 4) level of cooperation, and 5) equal regard for the opinions and decisions of all standing members. Percentages of the sample rating their team good, very good, or excellent on these dimensions ranged from 87% to 95%.

On the negative side, the Team membership was not representative of the target population in terms of ethnicity and socioeconomic status. Three-quarters of the sample of CART members were Caucasian; 17.5% of the sample were African-Americans, and 3.1% were Hispanic. The balance represented primarily Asian Americans. This is in marked contrast to the target population which is made up of high proportions of African-American and Hispanic families (exact figures are not available). Supporting the demographic data are the responses of CART members to the item of whether the CART was "representative of the community" in terms of race, ethnicity, and socioeconomic status. Nearly half (46%) rated the CARTs as deficient in this respect.

With respect to parent and youth participation in the program, the CART program appeared to be doing well in certain respects and poorly in others. CART members and parents alike reported that CARTs reach out to them. The majority of parents (63.2%) were involved in developing service plans, and 62.1% of the parents were involved in providing input regarding needs, issues, and concerns. However, a substantial minority of parents (37.4%) felt that they were not receiving enough support and encouragement from CARTs, and 35.2% of the parents felt that they did not have enough input into service planning. Thus far, parents did not appear to be participating as integral members of the Team, and the more traditional professional-client boundaries remained intact. These results suggest that parents need to be empowered to a greater degree.

Although CART members reported that youth were encouraged to participate in planning services, most youth reported only minimal involvement. Only a quarter of the youth said they had been involved in developing the CART plan and had a part in carrying out the plan. Engaging the plan and had a part in carrying out the plan. Engaging the youth in the CART process appears to require more aggressive efforts on the part of CARTs.

Smaller Family Child Teams are being established in certain counties. With the widespread use of such Teams, the CARTs may move closer to their goal of establishing professional-parent partnerships.

Families, not just the youth themselves, reported receiving services addressing a broad range of needs, thus providing evidence that the services are family-based, as well as youth-centered. Services were classified as non-traditional (e.g., paying for appliance repair), quasi-traditional (e.g., companion program), and traditional (e.g., case management, psychological counseling). While traditional services were the standard, received by nearly all families, almost two-thirds received quasi-traditional services and more than half received non-traditional services. Ratings of helpfulness varied little by category.

The most critical question of all concerned how helpful the new program was to the children and their families. The present data are based on our interviews with the 38 parents. We make no claim to have definitive answers to that question. The final answers must await the results of a larger statewide study using more rigorous methods. However, the data do provide some grounds for optimism.

The approach followed was developed by Magura & Moses (1986) and has demonstrated reliability and validity. The parent interview schedule contained questions about four types of problems: (a) the child's school adjustment, (b) conduct or behavioral problems, (c) psychological problems, and (d) parenting skills. For each specific set of problems, parents were first asked to indicate whether the problem existed when they first talked with someone from CART. If an initial problem was noted, they were asked, "Is this still true?" If the problem did not exist initially, the parents were asked "Is this true now?"

Questions pertaining to specific problems were followed by more general questions in which respondents were asked to indicate for each of the four areas the extent to which CART services had contributed to the improvement.

For each of the four problem areas an improvement score was obtained by calculating the percentage of initially identified school problems on which positive change had occurred by the time of the interview. Potential score ranges were zero to 100%. Categories were established based on the percentage of problems identified initially that were resolved by the time of the interview. Considerable improvement was represented by scores of 50% and higher (i.e., at least half the initial problems had been resolved); some improvement by scores greater than 0% to less than 50% (i.e., less than 50% of the problems had been resolved); and no improvement by scores of 0% (i.e., none of the initially identified school-related problems had been resolved). The results are shown in Table 1. By and large, the program seemed to correspond with positive changes for the youth and their families. Outcomes, as well as other findings based on our interviews with the small sample of parents and their children are tentative and will need to be examined in a larger state-wide longitudinal study.

The CART program appears to be measuring up in many respects but falling short in some. Top priority is being given to children with special emotional needs who are at risk of, or referred for, residential treatment. Team membership represents a broad range of clinical and case planning expertise. Greater attention, however, needs to be given to the composition of the CARTS so that, demographically, they are more representative of the target families. Steps need to be taken to socialize both professionals and clients into new roles which bring them into a more equal partnership. A limited exploratory study of families provides grounds for optimism about the program, showing that families and youth received the intended comprehensive and non-traditional services and that they appeared to be helpful. Given these preliminary results, it is critical that a more rigorous outcome evaluation with a larger sample be launched, and that the program incorporate a formal and ongoing system of monitoring both process and outcome on a statewide basis.

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Chapter 2

Managed Care in Children's Mental Health

Health Care Reform Tracking Project: Tracking State Health Care Reforms as they Affect Children and Adolescents with Emotional Disorders and their Families

Authors

Introduction Method The 1995 State Survey Results
Impact Analysis Preliminary Results Discussion

Introduction

The Health Care Reform Tracking Project is a five-year study designed to track and analyze state health care reform initiatives as they affect children and adolescents with emotional/behavioral disorders and their families. This is the only national study tracking state health care reforms as they affect this population. It is being conducted jointly by the Research and Training Center for Children's Mental Health at the University of South Florida, the Human Service Collaborative of Washington, D.C. and the National Technical Assistance Center for Children's Mental Health at Georgetown University.

Method

The first activity of this project, completed in May 1995, was a baseline survey of all fifty states to identify and describe current state reforms. The survey was sent to State Child Mental Health Directors and State Medicaid Directors. Responses were received from all 50 states and the District of Columbia. The baseline survey will be repeated in years 3 and 5 to see how things change over time.

The second phase of the study involves an in-depth study of reforms in a smaller sample of states, tracking over time the effects on service delivery to children with emotional disorders and on systems of care for this population. Structured telephone interviews and site visits will be conducted annually for this part of the project and will include data collection from a broad range of key stockholders, including parents, state administrators, local providers, and advocates. Questions explore a broad array of access, quality, cost and other issues.

The 1995 State Survey Results

The vast majority of states (86%) are involved in some type of health care reform activity. Nearly all health care reforms are focusing on Medicaid, and most (84%) involve Medicaid waivers.

Most states are in early stages of implementation or planning. Most reforms involve both physical health and mental health. However, nearly a third of the reforms are still limiting mental health coverage.

Of the reforms reported to us, most include substance abuse services as well as mental health. However, reforms focusing on mental health services are less likely to include substance abuse services; only half of the mental health-only reforms include some provisions for substance abuse services. This points out a lack of coordination between the mental health and substance abuse communities, which may be planning their reforms independently. Considering the high co-morbidity between mental health and substance abuse problems, this approach ultimately may not make much sense.

Most reforms focus on the entire Medicaid population (60%) or some portion of the Medicaid population. If states are incrementally phasing in the Medicaid population, our data show that they are most likely to start with the population which receives Aid to Families with Dependent Children (AFDC). In almost all cases, the reforms cover both adults and children (88%). Interestingly, if there is a special age-based focus, this tends to be on children rather than on adults.

In about 72% of the reforms, representatives of the state

In about 72% of the reforms, representatives of the state mental health agency were involved in the planning process. In most but not all cases, when the mental health agency was involved, staff from the children's mental health agency also were involved. However, when the reform covered both physical health and mental health, in about 40% of the reforms, state mental health agency staff were not at all involved (and, of course, neither were children's representatives).

With respect to differential coverage, children are more likely to get different treatment, which generally represents an expanded or enriched benefit package. However, the reality is that two-thirds of the reforms do not yet recognize that children may need a different service array or an enriched benefit package.

Most states are using some type of carve out arrangement for behavioral health services (72%). Some states have carved out mental health completely and are financing and administering these services separately from physical health. Others have divided the mental health benefit (i.e., they provide partial mental health coverage with the physical health benefit and then organize a separate delivery system for persons with serious disorders or leave this population out of their managed care systems). Still others are not using carve outs, implying that mental health services are integrated with the physical health service delivery systems. We found a great deal of confusion about the term "carve out;" the term was used in some cases to describe arrangements whereby certain services or population groups are actually left out of the managed care system.

The vast majority of the reforms (88%) involve the use of capitation. All of the mental health-only reforms use capitation. States are developing separate capitation rates for a number of distinct populations (e.g., for children in general, children with serious emotional disorders, and children in state custody). Most states are using costs associated with prior utilization as the basis for determining capitation rates.

In most states, only the state Medicaid and mental health agencies are contributing dollars to finance the capitation rate. In very few instances did states report that other child-serving systems are contributing funds to finance capitation rates for children with emotional disorders.

With regard to risk, more than half of the reforms are reported to be using some type of risk adjustment (61%) to protect children with serious disorders and to protect providers. States typically are protecting themselves as much as possible from financial risk.

States are using a variety of types of entities as managed care organizations; in most cases states are using multiple entities. There is extensive use of for-profit entities, but a significant portion of the reforms are using regional or local significant portion of the reforms are using regional or local mental health authorities or community mental health centers as the managed care organization. The data suggest that when the reform is focusing on mental health only, states are more likely to use their existing mental health structure for planning and administering service delivery than if it is a broader reform. The reforms covering both physical health and mental health seem to be relying more on the for-profit managed care entities or the for-profit managed behavioral healthcare entities. Less than half of the reforms are designating "essential providers" or providers that managed care organizations are obligated to use.

States are using a wide range of managed care techniques in the reforms they reported to us, including: (a) screeners or gatekeepers, (b) case management, (c) precertification, (d) concurrent review, (e) utilization review, and (f) preferred or exclusive provider arrangements. Only about a third reported that their reforms involved organized systems of care for children.

About half of the reforms report having some special management mechanisms for children with serious emotional disorders. These include mechanisms like intensive case management, provisions for service planning by interagency teams, and access to an enriched benefit package as noted earlier.

Around outcomes, we found that reforms are focusing on a range of dimensions. Cost, access, and utilization are the areas looked at most closely. Client outcomes and program effectiveness are the dimensions considered least in the reforms. Nearly 70% of the reforms reported that they are going to look at parent satisfaction as a dimension of outcome assessment.

Impact Analysis Preliminary Results

In the second phase of the Health Care Reform Tracking Project, now underway, we are exploring in greater depth the impact of state health care reforms on children with emotional disorders and their families and on systems of care for this population. Preliminary results were obtained from structured telephone interviews with 13 states, which included: Arizona, California,

Hawaii, Iowa, Massachusetts, North Carolina, Oregon, Pennsylvania, Rhode Island, Tennessee, Utah, Washington, and Wisconsin. These states were selected because they have some measureable experience with managed care and, as a group, provide differences in approach and geographic diversity. The preliminary information that follows is described primarily to give a sense of the kinds of issues being explored in the Phase II work. In most states, it simply is too early in the managed care initiative process to determine the impact on children and families. Hence, these issues will be followed more closely in follow-up visits.

The vast majority of states report that it is too early to tell what the impact is on child outcomes, if indeed this is even being tracked. Some states, however, are beginning to identify trends in service access.

Three of the ten states indicate that their health care reforms have made it easier for children to obtain mental health services, and two of the ten states say reform has made it more difficult, largely because medical necessity criteria restricts access to mental health services for children and the number of providers is more limited. Three of the ten states also indicate that more children are using mental health and substance abuse services as a result of their managed care initiatives. This is due to expanded coverage for uninsured and poor children and/or more Medicaid children using services. The other states say that it is still either too early to tell, or that there has been no effect on utilization. Most states are unable, at this point, to answer the question as to whether access to mental health and substance abuse services for different subgroups of children (i.e., children of color, children in child welfare, children in juvenile justice, children in special education, children with serious emotional disorders) is greater or less as a result of their managed care initiatives. It is unclear as to whether this is because it is too early to tell or whether states simply are not tracking access in this manner.

A split among the states exists over whether providers are willing to participate in the reformed system. There is also a split over whether the health care reform has meant a need for more or fewer specialized children's programs and practitioners. Six states report new types of providers and programs included in service networks through their health reforms, including: (a) social workers, (b) paraprofessionals, (c) hospital diversion programs, (d) wraparound services, (e) in home services, (f) partial hospitalization, (g) respite services, and (h) school-based services. One state reported that their reform reduced the number of providers and programs.

Most states report that more types of home and community based services are covered through their health care reform than previously. Most states also report a reduction in both the use of inpatient psychiatric hospitalization for children and the lengths of stay while utilizing inpatient. Two states report that their health care reforms have led to a reduction in out-of-home placement, but most states say it is too early to tell. One-third of the states, however, report an increase in the use of residential treatment centers, as well as "dumping" of children into residential treatment in the public sector.

Three states report increased costs associated with their health care reforms, largely due to increased access to services. Two states, however, report no effect on cost, and half say it is still too early to tell. Three states report a change in expenditure patterns, with a decrease in spending change in expenditure patterns, with a decrease in spending on inpatient and an increase for community-based services. Most states do not know the impact of their health care reforms on costs to other child-serving systems, such as child welfare. Half of the states report greater interagency collaboration as a result of their health care reforms, but two states report that their reforms have exacerbated the issue of which system should pay for which services for which children. Four states indicate that their reforms have enhanced their ability to pool funds across children's systems, but most states say it is too early to tell or report no effect. Four states also indicated an enhanced ability to use Medicaid to finance mental health services for children as a result of their health care reforms; one state reports a diminished ability.

Half the states report that the health care reform has facilitated their development of systems of care for children, and half say it is too early to tell. Most states report that their reforms have also facilitated their ability to provide flexible, individualized services for children, but that it is more difficult to coordinate these services. The vast majority of states report that the role of their public child mental health systems has changed as a result of their health care reforms, with public child mental health assuming more monitoring and training responsibilities and, in some cases, becoming strictly a long term care provider of services. Also, most states report more integration between the public and private sectors as a result of their reforms.

Four states report an expanded role for primary care providers in identifying and treating mental health problems for children as a result of their health care reform, and some states express concern over both the need for better linkages between primary care and mental health providers and the need for better training for primary care providers in mental health issues in children. Most states do not know or report limited impact on the extent of family involvement as a result of their health care reforms. Even the three states that reported support for family involvement in their reforms indicated a need to do more.

Most states find it too early to tell if quality of services has improved. Two states report better quality, and one, diminished quality, largely due to a reduced provider capacity and restrictions on length of stay that is leading to increased recidivism. Most states also say it is too early to tell or they do not know the impact of their reforms on the cultural competence of services provided to children. Three states, however, indicated enhanced cultural competence due to inclusion in the service network of culturally competent providers and training in this area. Finally, most states report it is too early to tell if their reforms facilitate or make worse the early identification of mental health problems; however, four states report it is easier to intervene earlier because managed care moves people faster through the system.

States listed the following as the most important things to avoid in health care reform with respect to children with emotional disorders and their families:

- Splitting acute and long term care responsibilities between the managed care entity and the public sector;
- cost shifting among child-serving systems and between the managed care entity and children's systems;
- exclusion of families and advocates from planning and implementation of the health care reform;
- assuming that private managed care organizations understand public sector clients;
- categorical funding of the health care reform;
- lack of outcome measures for children;
- inadequate provider network (i.e., not properly trained, not sufficient capacity, or not right types of providers in network);
- poor understanding of prior costs and utilization; and
- hurried planning and implementation.

Conversely, states recommended that the most important elements to include in state health care reforms are:

- A single system for children with serious and mild disorders, for acute and extended care needs;
- a broad, flexible array of covered services in the benefit design;
- a system of care approach for children with serious disorders;
- family involvement in planning and implementation;
- extensive interagency involvement in planning the system;
- mandate interdisciplinary treatment teams and interagency linkages in contract language;
- delineate funding responsibilities across children's agencies;
- create a citizens review board and a complaints resolution process;
- have good data systems to plan and monitor the system;
- undertake extensive public education about the new system; and
- go slow&endash;create a deliberate and open planning process.

Discussion

Not only are states proceeding quickly with their reforms, but they are moving ahead with statewide implementation for the most part, without the benefit of pilots or demonstrations. This highlights the need for careful monitoring and evaluation of these reforms as they proceed. It also increases the likelihood that states will have to make corrections to their systems over time.

The majority of the reforms still do not recognize that children may require a different service array, an expanded benefit package, or special requirements for service delivery like interagency service planning or family involvement, creating concern about the limited use of organized systems of care for children with serious emotional disorders in managed care systems.

The use of carve outs, and the type of carve out, for behavioral health services, is an area in which states' approaches are evolving and are likely to change over time. We will need to look very closely at how well states and managed care organizations are able to manage the boundaries between carved out, left out, and integrated populations. Otherwise, we will have a great deal of cost shifting and fragmentation of service delivery, especially for children.

There is a need for better data to use as the basis to determining capitation rates for children with emotional disorders. A lot more work is needed to figure out how to track outcomes for children and families in managed care. Much of the ongoing work in this area appears to be adult-focused.

The entire issue of family and youth involvement needs further exploration. Most states reported some level of family involvement in planning their reforms, but family involvement seems peripheral, for the most part.

Over the past decade, there has been increasing awareness of the differences between children's and adults' services. These and other differences must be accounted for as states develop and refine benefits, gatekeeping systems, treatment planning and review systems, quality and outcome measures, and all other facets of managed care. Given the profound implications that managed care is likely to have, we cannot underestimate the importance of involving those with children's expertise (i.e., staff and families) at the earliest stages. There is also a clear need to better integrate other children's systems, such as child welfare, education, and juvenile justice, into the planning of managed care systems.

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Symposium:

Public-Sector Managed Care for Children's Mental Health Services: Stakeholders' Perspectives

Authors

Introduction
Stakeholders' Perspectives: Overview of Carolina Alternatives
Stakeholders' Perspectives: Area Programs, Hospitals and Departments of Social Services
Stakeholders' Perspectives: Client Satisfaction and Outcomes
Stakeholders' Perspectives: Preliminary Cost

Introduction

Beginning in January 1994, North Carolina implemented a program that blended capitated financing with public-sector managed care for mental health and substance abuse services. The program is called Carolina Alternatives (CA), and it covers children eligible for Medicaid. This symposium is designed to outline the structure of CA and present stakeholders' perspectives on the first two years of implementation. The stakeholders to be represented include (a) the State's Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (MH/DD/SAS) and its local branches (Area Programs); (b) the state, private, and general hospitals that provide mental health and substance abuse services to children; (c) the county Social Service Departments (DSS); and (d) both the children who receive services and their parents. Initial cost findings on both inpatient and outpatient service delivery will also be presented.

Stakeholders' Perspectives: Overview of Carolina Alternatives

Dan Tweed, Ph.D.

During the late 1980's, the Health Care Finance Administration (HCFA) was concerned that Medicaid funds were being used to hospitalize children who might be better treated in other settings. Medicaid regulations require three criteria before a hospital admission qualifies for Medicaid reimbursement: (a) the child has a mental health condition warranting care under the supervision of a physician; (b) the child can benefit from hospitalization; and (c) more appropriate services are not available in the child's community.

In North Carolina, HCFA's concerns led to the implementation of a Utilization Review (UR) program in August of 1990. The program was designed by North Carolina's Division of Medical Assistance (DMA) and implemented by a private-sector managed care company operating under contract with DMA. Designed to ensure that Medicaid regulations were being observed, the UR program incorporated two of the fundamental tools of a managed care system&endash;a pre-certification review process designed to divert children from hospitalization when more appropriate forms of care were present, and a continued stay review process designed to ensure that children were not hospitalized longer than clinically necessary.

Only a subset of North Carolina's hospitals were initially targeted by the UR program, but this subset accounted for over 90% of Medicaid-reimbursed inpatient stays. Analyses suggested that the UR program appeared to be effective. Pre-post comparisons suggest significant reductions in the number of inpatient days provided, reductions in inpatient expenditures, and substantial savings for both North Carolina and the Federal Government.

Effective as it was, however, the program had obvious limitations. First, the program was designed as a simple UR strategy. Even though the program's mission included determining if more appropriate community-based services were present, it had no care management component. If a child was denied admission, there was no process in place to ensure that the child received an appropriate alternative service. Second, if the program was working as designed, the potential for further reductions in inpatient utilization was limited by the lack of community-based alternatives in the child's community of origin. Availability of community-based alternatives, in turn, was limited by the lack of funding to build good systems of care. What was needed was a managed care strategy capable of generating savings and converting those savings into alternative community-based services. Under the UR program, savings stayed in state and federal coffers.

stayed in state and federal coffers.

Carolina Alternatives

Beginning in April of 1991, North Carolina's Division of MH/DD/SAS collaborated with DMA to design a new program, Carolina Alternatives (CA), which could overcome the weakness of the UR program. During the first two years, CA was implemented in 10 of North Carolina's 41 Area Programs. This pilot period served to road test CA and set parameters needed for statewide implementation. Under CA, several things happened. First, the local Area Programs became responsible for the management of all medicaid-reimbursed services delivered to children in their service areas. This included responsibility for the utilization review process and responsibility for finding appropriate care when inpatient care was deemed inappropriate.

Second, in order to carry out the managed-care role, pilot programs were given a prospectively determined budget with which to provide or purchase appropriate forms of care. Pilot programs were expected to live within this budget and were at full risk for expenditures in excess of the budgeted amount. For the first two years of implementation, however, the pilot programs received a prospectively determined budget having two distinct components, one expressly designated for the purchase of inpatient services and the other for the purchase of outpatient services (including the full range of non-inpatient forms of care). Area programs were at full risk for the inpatient component only. Any savings accrued from diverting children to less costly community-based alternatives was kept by the Area Programs.

By contrast, the pilot programs enjoyed a two year "moratorium" on risk for outpatient expenditures. Pilot programs were reimbursed for excess outpatient expenditures, while unspent money was returned to the state. Outpatient expenditures during the moratorium period were used to determine the full capitation rate that went into effect at the end of the moratorium period. Thus, CA created a strong incentive to both divert children from inpatient services and spend money on the outpatient side. The intent behind this incentive structure was to provide a stimulus for the development of new community-based services.

Carolina Alternatives' design stimulated the development of community-based services along three lines. First, savings from reductions in the number of inpatient days purchased were used as flexible dollars to buy services which might otherwise not be covered under NC's mental health benefits structure. Alternative forms of residential treatment were included here. Second, the two year moratorium on outpatient risk created an incentive to shift the costs of caring for the needs of children with serious problems to the outpatient side, leading Area Programs to either invest in the development of new in-house capacity or to incorporate an expanding base of private contract providers. Finally, the program provided an incentive for hospitals to offer program provided an incentive for hospitals to offer outpatient alternatives to inpatient care. Faced with fewer admissions, fewer days, and fewer dollars, hospitals were induced to enter the outpatient services market in a more aggressive manner.

With these thoughts in mind we now review how the program has been working. We approach this question in two ways. First, we share the views of several key stakeholder groups whose views can fundamentally condition the success of a program like CA: (a) the pilot programs implementing CA in quite varied circumstances; (b) the inpatient providers whose activities have been profoundly affected by CA; (c) the DSS agencies who often see the same clients, compete for the same residential capacity and often seek mental-health care for their clients; (d) the patients and their families; and (e) the state Mental health office. Second, we review expenditure patterns on inpatient and outpatient services to determine the presence of program effects on expenditures.

Stakeholders' Perspectives: Area Programs, Hospitals and Departments of Social Services

Dalene Stangl, Ph.D.

Introduction

This section presents the perspective of three groups regarding how CA restructured service delivery, implemented care management, and redefined interagency relations. Problems encountered by each group are also presented. The three groups are (a) the 10 Area Programs responsible for care management, (b) the hospitals that provide mental health and substance abuse services to children, and (c) the DSS directors for each county. Each of these groups has an important stake in the delivery of mental health and substance abuse services to children, and hence, each group provides an essential perspective to understanding the inner-workings of this public-sector managed care program.

Methods

In July 1994, six months after initial implementation of CA, mail-out questionnaires designed by two authors (DT and DS) were sent to all 41 Area Programs. These questionnaires tapped general attitudes toward managed care and familiarity with CA. In addition, the 10 participating Area Programs were sent a second questionnaire that asked about initial management experiences. These latter questionnaires helped prepare the researchers for subsequent interviews. Personnel from participating Area Programs (i.e., CA coordinators, utilization review managers, management information system personnel and finance personnel) were interviewed face-to-face, on-site, at two time points. The first interview was conducted by two of the authors (DS and DT), during was conducted by two of the authors (DS and DT), during August/September, 1994. These interviews assessed the managed care strategy and service structure of each Area Program. The second interview occurred during February, 1996, 26 months into the program, and was conducted by one of the authors (DS). It was preceded by a single mail-out questionnaire to all 41 Area Programs that asked updated but parallel questions to the previous questionnaires.

Thirty-five hospital administrators responsible for negotiating service contracts with the Area Programs were interviewed over the telephone at two points in time. The first interview was in July/August, 1994, and the second interview was during July/August, 1995. The first of these interviews was conducted by the author (DS) and the second by a research assistant trained by the author (DS).

Finally 100 DSS directors were interviewed over the telephone during July, 1995. These interviews were conducted by a research assistant. Copies of interviews and/or questionnaires may be obtained from the author (DS).

Results

Area Programs

Modeling the structure of CA as a wheel, Medicaid and the State Office of MH/DD/SAS are the hub and the Area Programs are the spokes. The Area Programs carry the weight of the program in that they are responsible for implementation and are at-risk for excess expenditures above and beyond the capitation amount. They have expended a great deal of time, thought, energy, and patience in designing, implementing, and adapting to an evolving process. Most results presented here will be from the 26-month interviews conducted and questionnaires collected in February of 1996.

Service Delivery: All 10 Area Programs reported that CA resulted in decreases in the average length of time until children received first treatment. Estimates ranged from decreases of 1 to 30 days, with 5 days representing the median decrease. Of the 10 Area Programs, 9 reported increases in in-house direct care staff and/or treatment slots, in residential treatment slots, and in case management staff. All 10 Area Programs developed and maintained an extensive network of private contract providers. The number of contracts with individual care providers ranged from 10 to 78 (median = 32), and with group providers, ranged from 10 to 33 (median = 12).

Admission rates to hospitals from the 10 Area Programs decreased, and the average length of hospital stays were reduced to less than 30 days, with 9 of 10 Area Programs reporting average lengths-of-stay less than 14 days. Formal grievances from the hospitals were minimal with most Area grievances from the hospitals were minimal with most Area Programs experiencing no grievances that were unresolved at the local level.

Care Management: Area Programs were asked to report how extensive efforts to manage inpatient care were during the first two years of the program. On a scale of 1 to 7, (1 = Not at all Intense, 4 = Moderately Intense, and 7 = Extremely Intense), eight Area Programs rated their efforts as 5 or higher, with 4 rating their efforts as extremely intense. The 2 remaining Area Programs rated their efforts at level 3. On the outpatient side, Area Programs anticipate that efforts to manage outpatient care will have to be equally intensive with the onset of outpatient capitation.

After two full years of implementation, only 3 of the 10 Area Programs felt they were still at moderate risk of deficit spending for inpatient care. The remaining 7 reported very little or no risk of deficit spending for inpatient care. The opposite was true for deficit spending on the outpatient side. Here 7 Area Programs reported being at moderate to substantial risk of deficit spending. The other 3 programs reported little to some risk of deficit spending.

The most common barriers to managing inpatient care reported by the Area Programs was the lack of community-based alternative services. This barrier was reported by 8 of 10 Area Programs. Other barriers reported by at least 3 Area Programs were lack of experience with the managed care process and lack of clarity from the state.

The two most commonly reported barriers to managing outpatient care were poor communication with service providers and fluctuating expectations as the Area Programs move from outpatient growth to containment. Until January, 1996, Area Programs were provided full reimbursement for outpatient services. Now outpatient services are also reimbursed on a capitated basis. Hence, the first two years of CA resulted in outpatient service expansion, while January, 1996 marked the beginning of service containment. Area Programs reported nervousness about their abilities to maintain service provision at the same levels as the first two years of the program. Other barriers reported by at least 3 Area Programs included lack of sufficient community-based services, conflicting philosophies with service providers, and lack of clarity from the state.

Interagency Relations: As gatekeepers to service delivery and payments, Area Programs are the principle decision makers, and this may present a source of conflict for other agencies. Competent communication and negotiation skills are crucial. Questions pertaining to Area Programs' relationships with Department of Social Service, Juvenile Justice, and Education showed that while most relationships have some problems and some fluctuated frequently, 40% of the relationships remained the same, and 50% improved since the beginning of CA.

Other Results: Nine of 10 Area Programs described

Other Results: Nine of 10 Area Programs described dissatisfaction with their management information systems in at least one of the following areas: claims management, patient tracking, utilization review, and patient scheduling. All Area Programs attained savings from inpatient capitation reimbursements during the first two years of CA. Area Programs estimated that 22 to 58% of that savings was spent on administrating the program.

The final question asked of Area Programs was: "If CA ended today, how would you evaluate what it has done for children's mental health in your area?" The responses resonated a common chorus. Area Programs reported that CA has developed greater continuity of care for children by the improving quality and quantity of services and requiring accountability for the entire spectrum of care. Access to services has improved, with more children being served in each Area Program. Mental health centers are working pro-actively with communities to develop a wide spectrum of services. Communication has improved so that now information is passed with the child across episodes and providers. Accountability has increased, both in terms of fiscal responsibility as well as service provision. CA has provided better coordination and communication between all stakeholders in the process.

Hospitals

Hospitals are an important stakeholder in CA. As service delivery is restructured and less costly outpatient services substituted for inpatient ones, hospitals stand to lose the most. Because only about 30% of children eligible for Medicaid reside in the vicinity of participating Area Programs, the full impact of CA on hospitals has yet to be seen, but change is evident. As of July, 1995, 74% of the 35 hospitals serving children with mental health and substance abuse problems had signed a CA contract with at least one Area Program. The results provided below are from the July, 1995 interviews with administrators from these hospitals.

Service Delivery: Fourteen percent of hospitals reported plans to decrease inpatient capacity, and 80% of those planning a decrease, attribute their action to CA. Forty percent report plans to increase their outpatient capacity, and of those planning an increase, 43% attribute the change to CA.

Care Management: As of July, 1995, hospitals had signed a total of 61 contracts with the 10 Area Programs. Each hospital rated each Area Program with whom they had a contract on several dimensions of care management. Hospitals were asked whether Area Programs exercised too little, about right, or too much control on the hospitalization process. Sixty percent of the ratings fell in the about right category, and 27% fell in the too much category, down from 44% in 1994.

Hospitals also rated Area Programs on their ability to manage inpatient care. Seventy-five percent of the ratings fell in categories ranging from satisfactory to very well. When asked to compare the utilization review of the Area Programs to that of the private company providing the review prior to CA, 35% reported that the Area Programs were more responsive to the needs of children; 22% reported the Area Program and private company were about equally responsive; 22% reported Area programs were asked about responsiveness, and 22% did not know. Similar percentages were reported when the same question was asked with respect to the needs of the hospital rather than needs of the children.

Other results: Finally hospitals were asked to rate the impact of CA on the children they served. Forty-three percent reported that CA had a favorable or extremely favorable impact; 26% reported negligible, and 23% reported unfavorable.

Departments of Social Service

In most Area Programs, the transition of DSS into CA has not been smooth. Notions of medical necessity and treatment versus placement have been slowly accepted by DSS departments. Area Programs worry that the advances made with DSS departments during the growth in the uncapped outpatient services period will be lost as more stringent efforts at managing outpatient services are necessary under the second phase of CA. Results presented here are from telephone interviews conducted in July, 1995.

Service Delivery: DSS directors were asked the following question: As a consequence of CA, do you think that the mental health service options available to children eligible for Medicaid (1) Improved very much, (2) Improved, (3) Remained the same, (4) Deteriorated, (5) Deteriorated very much or (6) Don't know? Ten percent of the DSS departments in CA participating counties reported some level of deterioration, while 53% reported some level of improvement. The remaining 36% fell in the remained the same or don't know categories.

Care Management: DSS directors were asked the following question: Under CA, your local mental health agency serves as the single entry point for children needing mental health services; given your experience with the local mental health agency, how effective do you think they have been in this role? Of CA participating counties, 68% responded that Area Programs had been moderately or very effective in their role. Of the nonparticipating counties, who will eventually participate, 85% expect the Area Programs will be moderately or very effective in their managed care role.

Interagency Relations: Directors were asked to describe problems they encountered in their relationship with the Area Programs. The most frequent problem mentioned by

Area Programs. The most frequent problem mentioned by DSS was too slow or infrequent contact between agencies. This was true regardless of whether or not the county was currently participating in CA. Of the participating counties (n = 31), 23% reported this problem, while 36% of nonparticipating counties (n = 69) reported this problem. No other problem was reported by more than 10% of the participating counties. Among the nonparticipating counties, more than 10% reported problems with Area Programs in the areas of untrained staff, understaffing, misunderstood DSS functions, and inability to serve children with special needs. These percentages ranged from 12% to 17% of the nonparticipating counties.

Conclusions

CA has had its share of hurdles. These hurdles are reflected in the three perspectives presented here. The coming years will be no different, and tensions are likely to be exacerbated by capitated reimbursement for outpatient services and by implementation in the remaining 31 Area Programs. Area Programs will have a tough managed-care role as they tighten control on outpatient services. Interagency relations will continue to have ups and downs. Hospitals will continue to lose demand for inpatient services and need to substitute outpatient services. Area programs, DSS departments, and mental health and substance abuse service providers must continue to be flexible and creative as they are forced to adapt the service system to new financing approaches. Hopefully in the mission to improve both efficiency and effectiveness of treatment, CA will continue to increase access and delivery of a broad spectrum of community-based services.

Stakeholders' Perspectives: Client Satisfaction and Outcomes

Elizabeth M.Z. Farmer, Ph.D. & Julia S. Gagliardi

Children and families who use the public mental-health system are the most important stakeholders in CA. They are the ones for whom CA was created and the ones with the most to gain or lose depending on the success of the program. A set of measures was developed and pilot tested to explore both client satisfaction and to assess child outcomes.

Method

A team of individuals&endash;composed of representatives from the state Division of MH/DD/SAS, Area Programs, Family advocacy groups (Families Can and AMI), and Duke University&endash;developed the measures. The group focused their efforts on developing measures that met several core requirements. The measures must assess satisfaction and outcomes (process measures were already under discussion elsewhere), should be simple to both administer and interpret, had to tap "real world" dimensions, and should be useful to a variety of stakeholders (e.g., the local Area Mental Health Programs, the State, legislative committees). The committee recognized that the initial measures would be the first step in an ongoing process of development.

The child outcome measures included assessment of problems and functioning in six domains (i.e., (a) school/work/vocational training; (b) family/residential; (c) peer relations; (d) behavior; (e) substance use; and (f) involvement with the legal system). It also included a checklist of treatment foci and the Child and Adolescent Functional Assessment Scale (CAFAS; Hodges, Bickman, & Kurtz, 1991).

The satisfaction measures were designed to gather information at key points in a child's treatment process (i.e., at first contact with the center, at initial treatment planning, and at annual update of the treatment plan or planned termination of treatment). Each of these forms focused on issues that were of particular relevance at the given stage of treatment. In addition, a measure was designed to assess the satisfaction of families who dropped out of treatment.

Pilot data on the satisfaction measures were collected in nine Area Programs that were participating in CA. Data collection continued for one month and included all children and parents/guardians who met the criteria for the questionnaires (e.g., all clients who had a first contact, clients who had annual updates of treatment plans). Questionnaires were given to both a parent/guardian who accompanied the child and to the child (for children who were at least ten years old).

Questionnaires were completed while the family was still in the clinic and were returned in an envelope or to a "drop box" to insure confidentiality. Satisfaction of clients who dropped out of service were collected via telephone interviews with the parent/guardian.

Results

A total of 275 forms were included in the analysis. Of these, 115 were "first contact" forms, 68 reported on satisfaction at "initial treatment planning," 53 reflected views at annual review or planned termination, and 39 were completed by parents/guardians of children who had recently dropped out of treatment. Available data suggests a completion rate of approximately 79%, though this rate varied considerably across programs.

The following results highlight areas of particular satisfaction, as well as areas that showed room for improvement. At first contact, 99% of respondents expressed adequate satisfaction with their experience (i.e., 75% were very satisfied and 24% were somewhat satisfied).

Eighty-one percent reported that they were seen at the Area Program within two weeks of first calling to make an appointment, and 91% felt that this response time was satisfactory. Sixty-eight percent reported that they experienced no barriers or difficulties in obtaining services. Of those who did report difficulties, the most commonly reported problems were lack of transportation, lack of information, and concerns about costs. Other questionnaires continued to show an overall high level of satisfaction with services. Areas of particularly high satisfaction included communication (e.g., "staff members listened to what you said," "staff understood the needs of your child and family"), and efficacy of treatment (e.g., "treatment helped you deal more effectively with problems"). Areas that showed a need for improvement included parental participation in treatment planning and removing barriers to care to prevent families from dropping out of treatment.

Pilot testing of the outcome measure included 28 clinicians or case managers who completed the assessment on 41 active cases. Results indicated that the forms were acceptable to staff members, covered domains that they considered to be important, and could be completed in less than ten minutes.

The involvement of representatives from a variety of perspectives and organizations in the development of the satisfaction and outcome measures increased interest in the measures and willingness to implement them. Pilot testing showed that the satisfaction and outcome measures were acceptable to clients and staff members, could be completed quickly with reasonable return rates, and gathered information that was of interest and use to the intended stakeholders.

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Stakeholders' Perspectives: Preliminary Cost Findings

David Langmeyer, Ph.D.

This portion of the symposium presents a comparison of service costs between Area Programs that participated in CA and those that did not. Comparisons within each group across time are also presented.

Method

During the first two years of CA, the 10 participating Area Programs were paid a capitated rate for inpatient services and a fee-for-service rate for non-inpatient services, while the 31 non-participating Area Programs were paid a fee-for-service rate for both inpatient and non-inpatient services. Hence, all costs presented here were calculated based on fee-for-service rates. For this report, costs represent the Medicaid rate paid for services. It is the cost to Medicaid payers (Federal, State and County) on a fee-for-service basis.

Information about the costs under CA was gathered from the North Carolina Medicaid paid claims files for all Area Programs in 1992 and the non-participating Area Programs in 1994. For participating Area Programs, 1994 and 1995 information came from reimbursement reports of the North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services.

It is known that there is under reporting on the paid claims files. Not all services, particularly non-inpatient services, are reported. This underestimates the cost of non-inpatient services for both non-participating and participating programs in 1992, as well as for non-participating programs in 1994. The result is that cost increases for participating programs is exaggerated.

Results

From 1992 (before capitation) to 1994 (first year of capitation), total value of services for participating Area Programs went up by 72% (see Table 1). Non-participating Area Programs operating under fee-for-service increased total value of service by under 4%.

Some of the increase was due to an increased number of eligible children under 18. For CA participating Area Programs, there was a 26% increase in eligible months between 1992 and 1994. For non-participating Area Programs, this increase was 22%. Combining total value of service and number of eligibles, the cost per eligible month increased for participating Area Programs from 1992 to 1994 and decreased for non-participating Area Programs in the same period of time. Participating Area Programs increased cost per eligible month by 36% and non-participating Area Programs decreased cost per eligible month by 5%.

In general, CA was very successful in reducing costs associated with inpatient services. From 1992 to 1994, the cost per person served in inpatient settings dropped by 45% from $14,976 per person to $8,249. Non-participating Area Programs started at about the same level as participating Area Programs in 1992 and increased slightly in 1994 (+2%).

Offsetting the decrease in inpatient service was a dramatic increase in non-inpatient service for participating Area Programs. Value per person served in non-inpatient settings rose from $785 to $2,552, a 225% increase. There was also a sharp increase in non-participating Area Programs' value per person served from $603 to $1,466 (+143%).

The decrease in inpatient services and increase in non-inpatient services about balanced out. The total value per person served for participating Area Programs in 1992 was $3,203. This went up very slightly in 1994 ($3,280). The non-participating Area Programs were comparable (-4.3%) in 1992 (1994 was not available at time of the report).

Aside from increasing the amount of service provided, another feature of CA was to increase availability of services. Evidence supporting this accomplishment is provided by the fact that in 1994, participating Area Programs served 7.5% of eligible children compared to non-participating Area Programs serving 4.8% of eligible children.

The reduction in inpatient services was expected, and in fact, was the basis of undertaking CA in the first place, but the dramatic increase in non-inpatient services needs to be explored. One aspect of the increase is in the mix of services which were provided. In 1994, over 60% of the non-inpatient service dollars went for "High Risk Intervention." This service barely existed (as a billable service) in the 1992 paid claims files. A new service accounted for the increase in total value of non-inpatient services. Non-participating Area Programs seem to be following the same pattern as CA programs in the growth of non-inpatient services, but with a lag of a few months. The month-to-month paid claims for non-inpatient events in non-participating Area Programs grew rapidly from July 1994 until March 1995 (1.5 million to 3 million). It is likely that the differences in non-inpatient billing between participating and non-participating Area Programs will decrease when 1995 and 1996 information becomes available.

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Managing Care Through Limited Risk, Bundled Contracting

Authors

Introduction Project Description Conclusion References

Introduction

Managed care is becoming the major mechanism for the allocation and management of services and resources, not only for private health care, but throughout populations traditionally served by public service systems. This technology has moved into mental health services and is becoming the future of all child and family serving systems, including child welfare (Valentine, Fisher, Feild, Webman, & Web, 1995). This has led many communities to experiment with the key principles of managed care before converting to managed care in a formal sense. The summary describes a method of managing resources that builds on these principles in order to allocate a pool of blended, flexible dollars in Ohio's largest metropolitan county.

History

Franklin County has a rich heritage of intersystem and public/private collaboration. Individualized planning and creative funding have been important facets of the service system for high risk children and youth through Kids In Different Systems (KIDS), the local Child and Family First Intersystem Council, since 1992. The Council is comprised of the local child and family serving systems along with provider and parent representation (see Figure 1).

Through a pilot project called the 10 Kids Project, KIDS experimented with bundled contracting through a panel of private, non-profit mental health service providers. In this project, ten youths in out-of-county placements were brought back to their community through individualized planning and collaborative implementation (Cauble, et al., 1992). This project successfully demonstrated the effectiveness of collaborative planning when supported by flexible funding for serving high risk, high use youth with multiple needs. It also demonstrated better outcomes and cost efficiency by serving them in, or near their own homes. A second project demonstrated similar results with a group of multi-need children with mental retardation served by one, for-profit agency. In this project, the concept of limited risk contracting was formalized.

Objectives of Flexible Funding

Since late 1991, Franklin County has been committed to the flexible allocation of blended dollars to support individualized plans that are strength based and family centered. The following values were fundamental in the development of this process:

- Locus of decision making at the family team level (family centered).
- Optimum flexibility.
- Community flexibility.
- Accountability/tractability.
- Outcome oriented.
- Sensitivity to family satisfaction.

Objectives of Managing Care

The advent of managed care has created new demands on the allocation of flexible funds. The challenge in Franklin County has been to capitalize on the benefits of managed care for high-risk, intersystem children, youth, and families without compromising the gains made in the area of flexible, nontraditional individualized service delivery. The following principle tenets of managed care were incorporated:

- Limited risk contracting (Lindstrom, 1994).
- Increased flexibility for the provider (provider level risk management capabilities).
- Increased clinical flexibility and responsibility for the provider.
- Simplified standardization of (a) funding mechanism for individualized plans, (b) tracking of individualized planning, and (c) accounts servicing capabilities.
- Improved outcome and family satisfaction tracking, and feedback
- Increased risk management capabilities for the funders

Project Description

Structure of Contracting

The issues mentioned above create the value base on which the limited risk bundled contracting model employed in Franklin County is built. Contracting is done with individual providers and with a local Preferred Provider Organization (PPO). The contract itself coordinated funding agreements based on individual plans and budgets developed by the Child and Family team (CFT). After a plan and budget review process, the contract is written for the sum of the approved funding agreements with the particular agency or PPO (Figure 2 presents a flow of the contract process).

The contract allows the Lead Agency flexibility in using the grand total across individual plans. Hence the case manager has management capacity within the plan across line items (life domains), and the agency has larger risk management capacity across plans covered in the contract. In turn, the agency is responsible to provide (or contract for provision) and coordinate all services that are determined to be needed by the CFT. Since all planning and budgeting is a team centered activity, changes in services and expenditures are discussed in monthly team meetings and reported to the funder through meeting minutes, which are also published for all team members.

Upon the completion of the contract, which is renewed January 1 and July 1 of each year, the Lead Agency submits a Reconciliation which reports budget expenditures, actual receipt, and actual expenditures for each case and the contract as a whole. Payment is made in two quarterly installments over the course of a six month contract. The finalization of the funding agreements and the signing of the contract triggers the first payment in advance. This front loading is another strategy to support the providers ability to provide needed services without the concerns of cash flow, and to better manage their risk. The second payment is triggered by the receipt of all required submissions for the first quarter.

Limited Risk Structure

The contract is designed to provide some incentive for cost savings without creating the impetus to avoid the delivery of needed services. Monitoring through required submissions and a conflict resolution procedure supply additional points of accountability. The contract details a profit/loss window. If actual expenses fall under the budgeted amount by up to a designated percentage, the agency, or PPO keeps that amount. All monies saved beyond the window are returned to the funder. Likewise, if actual expenses go above the budgeted amount, up to the designated percentage, the Lead Agency is responsible for continued services provision without additional dollars. All additional expenses above the window are negotiated for reimbursement.

the window are negotiated for reimbursement.

Reporting and Monitoring

Fiscal information is provided mainly at the start and end of the contract period. Beyond this fiscal information, other reporting requirements are purposefully kept at a minimum in order to improve access to and the facilitation of services provided on the basis of flexible dollars. One required submission is team meeting minutes. The team is required to meet at least once every month to discuss progress, needed service, and budgetary changes. These changes, along with other pertinent information, are recorded in team meeting minutes in the interest of smooth communications and improved team functioning. These minutes are sent to KIDS as documentation of the team's ongoing planning and service provision, and changes in services and/or budgeting. The contract also requires submission of documentation of the tracking of seven behavioral indicators on a daily basis.

Family Satisfaction and Dispute Resolution

Another facet of monitoring contracted services is coordinated directly from the KIDS office. Family satisfaction surveys are conducted on a quarterly basis. The survey, developed through a series of parent focus groups, provides a direct link between funder and consumer. The contract indicates that the Lead Agency will be notified if family satisfaction levels fall below a certain point. This notification is intended as the completion of a necessary circle of communication connecting the funder, the provider, and the consumer. Such communication builds trust, which is the necessary element in any real quality improvement process. Complaints regarding service provision coming from participating systems are handled in similar non-threatening ways through procedures internal to KIDS, but developed in conjunction with the PPO. The major thrust is on communication links and trust. If the complaints persist, a more formal resolution conference may be held.

Conclusion

On a small scale, Franklin County has experimented with managed care principles based on individualized planning that is strength focused, needs driven, and family-centered. These experiments have led to a method of contracting that appears to maintain the integrity of individualized services, flexible funding, and financial accountability, while creating a foundation for managing services on a much larger scale. On this foundation, we can move in a variety of directions, such as a leveling or case rate system, as we develop the best structure of managed care for our community.

Financially, the purpose is to create a situation of shared risk. It is important that the providers actually assume risk, as opposed to passing the cost of the risk on by inflating service and/or overhead costs. It appears that we have been successful in this area thus far. The overhead costs have been predetermined through a time study process and it is evident that providers have not offset the assumption of real risk by increasing service costs. Figure 3 outlines average daily costs before and after the implementation of bundled contracting. The increase observed at the time of bundles contracting can be attributed to a change in Medicaid billing rules in the State of Ohio. In the following period, the average daily costs return to previous levels. Patterns of inflation in services costs will be monitored in order to determine continuous success.

However, the success of this process of managing care through limited risk bundled contracting can not be judged solely on management and financial criteria. Innovations in managed care cannot be made at the expense of front line flexibility needed to serve children and their families with high level, multiple needs. The contracting mechanism described here has been in place for six months. Although it is too early to be conclusive, the initial impressions are favorable. With a multiple of changes occurring around (a) federal, state, and local funding strategies, (b) methods service provision, and (c) outcomes collection, it is impossible to single out particular effects of these contracts with extreme clarity. However, we have anticipated some impact from the implementation of this contracting. For example, we can look at behavioral indicators tracked during the service period. The indicators traced are alcohol and drug use, suicide attempts, AWOLs, assaultive behavior, self-injurious behavior, missed school, and arrests. During this contract period we have seen a slight increase in the number of days containing key behavioral indicators (see Figure 4). It is probable that the stress placed on outcomes in the contract will serve to increase the accracy of target behavior measurement.

We also anticipate that family satisfaction with planning and services will not be adversely effected. Further, it is hoped that this way of managing services will eventually serve to increase family satisfaction, and, conversely, that the need for outside conflict/dispute resolution will decrease.

Only through successful management of resources can we hope to make individualized service approach the norm, as opposed to the exception. We believe that this model of contracting provides a solid starting point.

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Managed Care Approaches to Children's Services within Public Systems of Care

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Introduction
Clinical Experiences in Managed Care Implementation for Children with Serious Emotional Disturbances
Best Principles for Managed Care Request for Proposals

Introduction

Over the past three to five years, there has been a rapid transition to managed care models of health care financing and organization in the United States. This transition is now reaching the area of public mental health services. As states and governmental entities seek to control the increasing costs of Medicaid programs, many are moving towards implementation of managed care principles in the funding and delivery of mental health services. States are pursuing different models of managed mental health services under both the 1150 and 1915 Medicaid waivers, some contracting with established managed care providers and others attempting to convert components of their public systems into managed networks.

This transition, however, is not based on any solid data concerning the funding needed to serve populations traditionally served by the public mental health system, nor has it been based on any of the solid conceptual models and principles which have been tested with these populations. The managed care models which have been typically implemented by managed care contractors have not taken into account the special needs of Medicaid-covered populations. These special needs include children with severe emotional disturbances and other disabilities, economically distressed families, and members of under-served minority groups, as opposed to the majority middle class populations around which managed care services were initially developed.

This oversight has already led to adverse consequences in some state managed Medicaid contracts where the needs for services in these populations (and the consequent capitation) was grossly underestimated. On the other hand, many state mental health agencies are attempting to convert into managed care organizations and funding of services, but often without the infrastructure support for a successful conversion.

These summaries will address conceptual and infrastructure issues which both traditional managed care providers and converting state mental health systems must face to make an effective transition towards a managed care organization of services.

Clinical Experiences in Managed Care Implementation for Children with Serious Emotional Disturbances

Theodore Fallon, M.D., M.P.H.

The Robert Wood Johnson Foundation funded eight demonstration sites around the country with the goal of constructing arrays of service that might address the range of needs for the most disturbed children and youth and their families. The actual structures of these programs varied considerably and were each suited for the political, social, and clinical climate in which they were implemented. This project, the Mental Health Service Program for Youth, yielded eight examples of what is possible given adequate resources.

Clinical aspects of these programs were examined by observing the clinical work through case conferences by visiting clinicians. The success of these programs in working with these disturbed youth and their families seemed to be dependent on a number of attributes:

1. The services provided impact on all aspects of the youth and his family's life. At a clinical level, this translates into multiple system involvement including juvenile justice, child welfare, education, and mental health. On a systems level, this translates into pooled funding of these agencies, in essence, pooling an array of resources and flexibly determining their most efficacious use. An example of this was seen at one site when a physically large adolescent repeatedly threatened the residential staff. During these times, the juvenile justice system allowed use of the detention center for time out periods. The youth was able to settle down enough to use residential support and educational services, and eventually the youth became a good student.
2. This example also illustrates the utility of coordinated services.
3. Services also need to be attractive. Many examples were seen in which youths and families had repeatedly rejected services, but when the services offered something desirable, families used them and in that setting were able to develop alliances with workers.
4. The services that were the most successful involved

4. The services that were the most successful involved considerable creativity in the service of being responsive to the youth and family. This means that the clinicians had control of the services and access to experts if they themselves were not expert. This expertise involved two components: (a) knowledge and practical skills in engaging and holding on to the families and children (characterized by focusing on the child and families' strengths, building rapport and self esteem); and (b) knowledge and practical skills in assessing and working with deficits including psychopathology (necessary in order to know how to direct the rehabilitative services that were needed to move the child and family toward normal development).
5. The services needed to have sufficient resources to be able to sustain them for as long as was necessary. This required a commitment on the part of the organizations involved (i.e., an ability to withstand the political changes as well as the personnel changes). This attribute seemed to be the most difficult to attain, especially in the environment of managed competition where competition implies competition of services where one naturally displaces another.

These five attributes were present to some degree in all of the systems of care that were able to make gains in working with children and youth with serious emotional disturbances.

Best Principles for Managed Care Request for Proposals

Andres J Pumariega, M.D.

Children and adolescents covered by Medicaid often have multiple developmental needs and complex problems. Effective intervention thus needs to include a full array of services in a community-based system of care, based on Child and Adolescent Service System Program (CASSP) principles. The American Academy of Child and Adolescent Psychiatry's Task Force on Community Systems of Care, in collaboration with other mental health professional and service associations and organizations, has developed a document titled Best Principles for Managed Medicaid Request for Proposals.

The Best Principles for Managed Medicaid Request for Proposals is designed to assist state decision makers in selecting managed care Medicaid vendors or developing public managed systems that can most effectively serve the population of Medicaid covered child population, particularly multi-problem children with severe emotional disturbances. It defines principles that should be inherent in high quality programs. It addresses such issues as governance of service systems, design of benefits, access to services, development of treatment plans, triage and assessment, treatment services, case management, quality assurance, information management, and provider support by states.

Providing a full continuum of services allows the care providers to customize the care plan to most effectively help the patient and family. The focus of such a model is on managing services rather than managing benefits a priori, which is discriminatory and restrictive with under-served populations. This model also ensures coordinated care and the establishment of communication and collaboration across disciplines and agencies for effective coordination of services. Care plans must be patient and family centered, with their full involvement in the assessment and treatment processes. These programs also need to develop programs and monitor outcomes in the following areas: (a) access, (b) functional and clinical outcomes, (c) prevention, (d) wellness, (e) community acceptance/responsiveness, and (f) patient/family satisfaction.

This document has been forwarded to all 50 Medicaid directors, and has received overwhelming positive responses, including responses from over 40 states requesting more information and consultation. Information regarding the principles covered in this document, as well as the approaches being considered to evaluate its adoption and implementation can be obtained from the author.

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Symposium:

The Impact of Managed Care on the Utilization of Child and Adolescent Mental Health Services: Recidivists in an Emergency Screening Team Site

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Impact of Managed Care on the Clinical Profiles of Recidivists

Factors Contributing to a Child or Adolescent Becoming a Recidivist at an Emergency Mental Health Screening Site Pre- and Post-Managed Care

The Question of Patterns of Dispositions

Introduction

This collection of summaries presents the latest analyses of data addressing the role of system changes in decision-making and service utilization in child and adolescent (C/A) mental health emergencies. In Massachusetts, private management of mental health and substance abuse benefits in the public sector began in 1992. Since then, increased management of these benefits has occurred in the private sector as well. The findings reported in this symposium are part of on-going efforts to evaluate private sector strategies to manage public sector mental health benefits.

In previous analyses (Young, Simon, Nicholson, & Bateman, 1996), the Child and Adolescent Service System Program (CASSP) concepts of least restrictive environment, community-based services, and individual need provided a framework for exploring the contributions of demographic, clinical, and fiscal variables to dispositions in emergency mental health screening of children and adolescents, before and after the private management of Medicaid benefits. As expected, the volume of screening episodes increased after managed care was implemented. There was, however, a significant decline in the proportion of dispositions to inpatient hospital settings, suggesting that children's needs were being met in less restrictive settings after the implementation of the managed care program.

During the same time period, there was a significant increase in the number of dispositions to community-based crisis stabilization programs, indicating that many children who would have been hospitalized were being diverted to community-based programs after the implementation of the Medicaid managed care program. Those emergency episodes in which children and adolescents were in greatest clinical need, however, continued to result in hospitalizations after the implementation of managed care, suggesting that children's individual needs were factored into decision-making.

In this symposium, we present three analyses of data from C/A recidivists at a mental health emergency screening site in pre- and post-managed care time periods, defined by the implementation date for Medicaid managed care. These analyses were conducted to address the fears of many clinicians that, in a managed care environment, clients are provided brief, "band-aid" services that do not fully address underlying problems. The assumption made by many clinicians is that utilization reviewers are reluctant to approve more costly services that clients may really need, or that they will not approve them until less costly services have been tried. The common concern is that clients will have to keep coming back for treatment until their needs are adequately met.

The following questions were addressed regarding the impact of managed care on recidivists at an emergency screening site:

- Was there a change in the number of recidivists and, specifically, in the number of Medicaid recidivists following the implementation of managed care?
- Which clinical, client, and fiscal variables predicted becoming an Emergency Mental Health Services (EMHS) recidivist in the pre- and post-managed care periods?
- What were the disposition patterns for recidivists in the pre- and post-managed care periods?

Method

Data for all three analyses were drawn from the daily log sheets of the EMHS program at the University of Massachusetts Medical Center in Worcester, MA. These logs contain: (a) demographic and clinical characteristics for clients receiving services, (b) type of insurance, (c) referral source, and (d) disposition.

We looked at clinical and fiscal variables and dispositions for children and adolescents over a

2-1/2 year period from October, 1991 to March, 1994. We divided the 2-1/2 year period into 3 parts: (a) pre-managed care (i.e., one year prior to the implementation of managed Medicaid mental health benefits on October 1, 1992); (b) a six month transition period; and (c) post-managed care (i.e., the year following the start-up of the managed Medicaid program). We did not include the transition period in our analyses to avoid drawing conclusions based on the normal fluctuations that are involved in any major systems shift.

Although Medicaid recipients account for the majority of EMHS episodes across the 2-1/2 year period, EMHS also became the screening site for a number of private managed care organizations during this time. Therefore, the research period really represents a time of overall systems change. For this reason, both Medicaid and non-Medicaid recidivists were included in our analyses, unless otherwise noted.

Impact of Managed Care on the Clinical Profiles of Recidivists

Lorna Simon, M.A. and Stephen Dine-Young, M.A.

In this summary, demographic, clinical, and insurance profiles of C/A recidivists in the pre- and post-managed care periods were compared using chi-square tests. Again, clients screened in the transition period were excluded.

There were a total of 482 children and adolescents seen in the pre-managed care (10/1/91 to 9/31/92) and post-managed care (4/1/93 to 3/30/94) periods. Of these clients, 101 were recidivists. The clinical and payor characteristics of the recidivists are presented in Table 1. The gender split was relatively even. A majority of recidivists were adolescents, and most either lived with family or at a residential treatment facility. The difficulties that recidivists were most likely to present with were harmful to self or other and problem behaviors (i.e., "acting out"); these difficulties corresponded to frequent diagnoses of disruptive D/O, Post Traumatic Stress Disorder (PTSD)/Anxiety D/O, and Adjustment D/O. Over two-thirds of the recidivists had Medicaid insurance, while most of the remaining clients had some form of private insurance (either indemnity or HMO).

Of the 101 C/A recidivists, 37 (17% of the total C/A clients) were screened in the pre-managed care period, and 64 (24% of the total C/A clients) were screened in the post-managed care period&endash;an increase that was statistically significant ($c2 = 4.01$, $p < .05$).

Although none of the clinical or demographic variables were significant across the two time periods, there was a statistically significant increase in the proportion of recidivists who were Medicaid beneficiaries in the post-managed care period (75% versus 54% in the pre-managed care period; $c2 = 4.65$, $p < .05$).

There was an increase in the number of emergency room recidivists after the implementation of managed care. This difference can be attributed to the management of benefits through support by the additional finding that there were no differences in clinical characteristics in the pre- and post-managed care periods, suggesting that there was little change in the client population across the two time periods. The finding that a larger proportion of the recidivists were Medicaid clients in the post-managed care period can probably be attributed to new regulations requiring that all Medicaid clients be screened at EMHS before receiving other services.

Factors Contributing to a Child or Adolescent Becoming a Recidivist at an Emergency Mental Health Screening Site Pre- and Post-Managed Care

Stephen Dine-Young, M.A. and Lorna Simon, M.A.

In the second summary, demographic, clinical, and insurance variables were tested as predictors of C/A clients becoming recidivists before and after the implementation of managed care.

Method

Logistic regressions for the pre- and post-managed care time periods were conducted to predict the odds of becoming a recidivist, as determined by more than one visit to EMHS during the time period. For each of the periods, the following predictors were considered: age, gender, diagnosis, and insurance. Adjusted odds ratios were calculated for each predictor.

Results

The results of the logistic regression for the pre-managed care period are presented in Table 2. Only a diagnosis of adjustment disorder significantly predicted whether a C/A client became a recidivist in the pre-managed care period, and the relationship was negative ($\beta = -1.69$; $p < .01$). A child diagnosed with this a disorder was less than one-fifth as likely to be an EMHS recidivist than a child diagnosed as likely to be an EMHS recidivist than a child diagnosed with disruptive D/O.

The results of the post-managed care logistical regression are presented in Table 3. Again, only the coefficient for adjustment disorder was significant and the relationship was negative (ß = -1.04; $p < .05$). In addition, being a Medicaid client also significantly predicted whether a C/A client would become a recidivist (ß = 1.42; $p < .001$). Medicaid clients were more than 4 times as likely to return to EMHS than non-Medicaid clients.

It also should be noted that in the pre-managed care period there was a trend toward significance for mood disorders (ß = 1.87; $p < .1$) and PTSD/Anxiety disorders (ß = .98; $p < .1$). These trends were not evident in the post-managed care period.

Conclusions

The finding that adjustment disorder negatively predicted a C/A EMHS client becoming a recidivist in both the pre- and the post-managed care periods is understandable in that it is the least severe of any of the diagnostic categories; clients assigned adjustment disorder diagnoses are probably less likely to need repeated care. Given the post-managed care period requirement that Medicaid recipients be screened at EMHS, the finding that having Medicaid insurance significantly predicted a C/A client becoming a recidivist also is not surprising.

Clinicians may be concerned about the trend toward significance with the diagnoses of mood disorder and PTSD/anxiety disorder in the pre-managed care period that did not exist in the post period. While these findings are not strong enough to draw clear interpretations, there is some indication that clinical factors are being given less consideration in the post-managed care period. Further investigation is necessary.

The Question of Patterns of Dispositions

Joanne Nicholson, Ph.D. and Joseph R. Mara, B.A.

In this summary, levels of restrictiveness of dispositions for C/A mental health emergency screening recidivists in the pre- and post-managed care period were considered. In previous analyses (Young et al., 1996), it was found that although emergency screening volume increased significantly in the post-managed care period, admissions to inpatient settings significantly decreased. In addition, this decrease seemed to be in direct proportion to the volume of episodes resulting in referrals to newly developed crisis stabilization programs (e.g., community-based care). It was assumed that an increase in referrals to community-based services was a good thing.

There are questions, however, that may nag certain stakeholders (i.e., both providers and consumers). Does this increase in referrals to community-based services reflect a lack of access to the appropriate level of care for those children and adolescents in greatest clinical need? Also, do children keep coming back until their needs are ultimately addressed via the inpatient level of care they really needed in the first place? If this is the case, costs, both dollar and clinical, may only be delayed and higher as an end result.

Method

We developed a very simple coding scheme for describing the pattern of dispositions for C/A mental health screening recidivists. We examined the dispositions for recidivists over time, and if the level of restrictiveness of the dispositions remained the same, a code of "no change" or "=" was assigned. If the level of restrictiveness of the dispositions decreased over time, this was coded as "decrease" or "-." If the level of restrictiveness of the dispositions increased over time, this was coded as "increase" or "+."

There is a weakness in this strategy; change over time was condensed into one code. In doing this, important information was lost that may have contributed to changes in dispositions over multiple emergency screening episodes (e.g., changes in age of the child or adolescent and related changes in available service options and the developing course of a disturbance or disability).

Chi-square tests were used to determine if there were significant differences between pre- and post-managed care periods in patterns of dispositions.

Results

None of our independent variables (i.e., clinical and payor characteristics) were related to change in level of restrictiveness of dispositions in the pre- or post-managed care periods, either for the total group of recidivists or the Medicaid subscribers who were recidivists. It would seem that the implementation of managed care had no impact on the pattern of restrictiveness of dispositions for this sample, as far as our simple coding scheme could detect.

Discussion

One way to think about this finding is that children are continuing to receive the care they need. There may be something about their ages or stages of illness that is more powerful than the payor variable in determining disposition.

There was no increase in numbers of children and adolescents in the increasing level of restrictiveness group, which would have suggested that children were being kept from the level of care they required until the gatekeepers, despite their efforts to contain costs, could no longer deny them access. Rather, we still see the same proportions of children for whom alternative plans are tried before they are hospitalized. And, even if they are eventually hospitalized, there may be some clinical benefit to trying alternatives first.

What is clear is the need for coordinated evaluation efforts among public and private sector agencies and providers if we are to truly understand the impact of managed care on such important issues as decision-making, service access and quality of care.

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A Community-Based Continuum of Services Compatible within the Managed Care Environment

Authors

Community-based Treatment Hubs

The Spurwink School offers a series of treatment "Hubs" that are positioned in a tri-state area. This summary outlines the "Hub" model and its key features.

Administrative Structure

The continuum of services within the Spurwink system involves community based programming in a wide geographic area in the states of Maine, New Hampshire, and Rhode Island. This involves a central administrative structure as well as decentralized program supervision structures. The central administration is involved in such activities as financial administration and accountability, program coordination, training, governance, computerized systems, human resources coordination, clinical and educational oversight, quality assurance, licensing, accreditation, government relations and fundraising. The decentralized supervision is based on the use of program directors who provide oversight to clusters of programs which are based upon the categories of services and clients, the geographic location or the setting in which services are provided.

Within the children and adolescent segment of the program, the geographically specific day treatment centers serve as "Hubs" for the day and residential programming; each has a program director. Program directors also serve an integral function at the adult developmental disabilities day activity and residential programs, the Spurwink Clinic and the two residential treatment centers, including the specialized adolescent and the long-term staff secure programs. These program directors are the vehicle for communication, quality assurance, training, financial accountability, treatment, education, and various other activities. This entire model involving a central administrative structure and a decentralized program supervision structure managed by a program director assures integration of services and accountability.

The Generalist Model

The core of the treatment activities is via the professional identified as "Generalists." The generalist became the core of the treatment paradigm employed at Spurwink; and thirty-five years later, across three states and more than 60 sites, it remains the philosophical approach; and importantly, the key to its managed care activities.

This generalist model was developed from the recognition that child care workers and teachers are the core professionals most exposed to the challenging behavior of kids with emotioonal or behavioral disturbances.

In order for these front-line workers to be effective, immediate, and responsive, support services and supervision are required. This is the role of the generalist - the one who integrates and coordinates all that goes on in the life of a particular child. The generalist is responsible for working with the child's family, working with the clinical staff, working with child care workers, and working with teachers. The task is to communicate, integrate, translate, support, and supervise.

The generalist model recognizes the fact that fragmented children and families cannot effectively be treated with fractionalized services.

The fascinating reality of this model has been its adaptability. Established as a key component of residential treatment, the generalist has been used effectively in day treatment, adult intermediate care facilities and community based residences designed to bring youngsters out of intensive in-patient facilities.

With this as its philosophical core, it is easy to see why Spurwink began to expand its mission in a decentralized fashion. Each community that was developed was designated as a "Hub." For every hub there is a series of residential alternatives, a day treatment site, a cooperative relationship with a public school and a network of consultants and providers, ranging from psychiatry to nutritionists to vocational training specialists. Each community "Hub" and all of its components are linked together and held accountable by the Generalist, the treatment "Hub."

Given the least restrictive to most restrictive, definition of the residential continuum, Spurwink was able to respond quickly to being able to accept difficult to place and difficult to manage youngsters. This also permitted intra-agency movement of youngsters, if necessary. Because of this Spurwink developed the reputation of being flexible and adaptive. Of course, this is a core requirement within the managed care paradigm.

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Chapter 3

Accountability & Information Systems

Symposium

The Ecology of Outcomes: Successful Approaches to Building Outcome Accountability

Authors

Introduction

Ecology of Outcomes

Utilizing the Results Implications for Children's Mental Health References

The Development of a Continuous Evaluation System for the Texas Children's Mental Health Plan: Building an Evaluation-Stakeholder Feedback Loop

Description of the Evaluation Evaluator-Stakeholder Feedback Loop Discussion

SumOne for Kids: Measuring and Improving Results in Services for Children and Families

Lesson 1 Lesson 2 Lesson 3 Lesson 4 Lesson 5 Lesson 6 Lesson 7 Lesson 8 Lesson 9 Discussion

Introduction

A growing sense of urgency regarding the need to reform present patterns of delivering human services to children and families underscores the need for systems to have mechanisms that ensure accountability. One strong element of this reform is that human services need to become accountable for achieving measurable outcomes rather than continuing to focus on technical compliance with rules or on simple demonstration of service need. Doug Nelson, Executive Director of the Annie E. Casey Foundation notes, "It has become a well-worn observation that success in human services is too often measured by persons served or services provided and too rarely by results achieved. Difficult though it may be, the reform required is clear. Helping agencies, service programs and schools need to be held genuinely accountable for progress on specific, publicly articulated and accurately tracked outcomes for the children and families they serve." (Nelson, 1993). The summaries that follow describe an evolutionary process for incorporating use of outcome information into planning and program development.

The opening summary of this symposium presents the Ecology of Outcomes framework, an overall framework designed to guide the development of outcome information systems. This framework provides a foundation for utilizing outcome information in ways that provide opportunities for learning and self-correction; it emphasizes using outcome information to inform decisions that shape service planning and delivery. As discussed below, components of the Ecology of Outcomes framework include the Principles for Outcome Accountability, Prerequisites and Building Blocks for building outcome accountability, guidelines for Implementing an Outcome Information System, and an approach for Utilizing the Results. This framework was developed through the System Accountability Study, an initiative of the federally funded Research and Training Center for Children's Mental Health.

During the symposium, three presentations described initiatives that exemplify the principles and components of the Ecology of Outcomes. These included development of the statewide information system for the Texas Children's Mental Health Plan; lessons learned from the Pennsylvania's SumOne for Kids, developed by Pressley Ridge School; and California's system of care approach to outcome tracking. Summaries of the Texas and Pensylvania activities are presented in this volume.

The Ecology of Outcomes: System Accountability in Children's Mental Health

Mario Hernandez, Ph.D. & Sharon Hodges, M.B.A.

Introduction

A fundamental reason for tracking outcomes in applied service settings is to determine whether the person receiving services benefits in an observable manner as a result of the services provided. For the purposes of this summary, outcomes are defined as the results or the impact of services provided to children and their families. Furthermore, outcome accountability can be defined as the systems of care's responsibility for accomplishing publicly articulated goals of service provision, as measured through accurate monitoring over time.

The purpose of this summary is to present a framework that can serve as the foundation for utilization of outcome information to provide opportunities for learning and self-correction. The four sets of components of the Ecology of Outcomes framework include 1) Principles for Outcomes Accountability; 2) Prerequisites and Building Blocks for building outcome accountability; 3) guidelines for Implementing an Outcome Information System; and 4) an approach for Utilizing the Results. The Ecology framework's emphasis on outcome information as a resource for use in decision making is evident in the Principles for Outcome Accountability. The next sections of this summary present the principles for outcome accountability, and then discusses each component of the framework.

Principles for Outcome Accountability

Stroul and Friedman (1986) recognized that although the components and organizational structure of a child-serving system might vary from state to state or community to community, the development and implementation of a system of care should be guided by a set of values and principles. Similarly, there are principles central to the successful development and integration of outcome information into the planning and delivery of services that transcend the variability and unique characteristics of any child-serving system's components and organizational structure. Ten guiding principles have been identified for the development and utilization of outcome information in systems of care (Hernandez & Hodges, 1996). These principles, listed below, are central to the design and operation of an outcome accountability approach because they specify what drives and shapes the development and implementation of the framework.

1.Outcome information cannot be collected in isolation of information about who is served and what services are offered.

2. Outcome information should be used to improve service planning and delivery

3.Outcome information should be relevant and accessible to key stakeholders in the system of care.

4.The application and use of outcome information should be informed by the available research base.

5.Outcome information should support culturally competent decision making in service planning and delivery.

6.Key stakeholders should be involved in identifying and selecting outcomes to be measured.

7.Data elements for the outcome measurements should be clearly defined.

8.Outcome information should be useful to managers, administrators, and direct service providers.

9. The process for collecting, analyzing and communicating outcome results should be timely and occur on a predictable schedule.

10. Outcome information should provide the opportunity for corrective action.

Prerequisites and Building Blocks

Prerequisites and Building Blocks, discussed below, are two essential components of successful implementation of an outcome accountability approach. They should be seen together as laying a foundation on which accountability can be built and thrive (see Figure 1).

The purpose of the Prerequisite component is to assess a service system's level of commitment to building an outcome accountability system. In essence, the Prerequisite phase should be used to determine if there is enough momentum and motivation to establish and sustain an outcome system. Two aspects, leadership and political climate are key to the Prerequisite phase of the Ecology of Outcomes framework.

The Building Blocks component represents the development of a plan for building and implementing an outcome system. The primary tasks for this component involve clarifying the reasons for developing an outcome system, describing what needs to be accomplished in order to implement accountability, and determining baseline levels to establish the current status of relevant data. The primary aspects of the Building Blocks phase of development are (a) establishing a process for involving stakeholders; (b) clarifying the language of outcome and accountability; (c) assessing current capacity for building a system of outcome accountability; and (d) planning for implementation.

The significant challenge inherent in both components is building a shared vision among stakeholders about what shape the accountability approach will take when complete. While this can be a formidable task, if not addressed, it can lead to a breakdown in the development process (Meadowcroft, Pierce, and Beck, 1994).

When successfully completed, activities described by the aspects of Building Blocks and Prerequisites components yield consensus among key stakeholders about who the system hopes to serve, what services are expected to be provided, and what outcomes the system hopes to produce. All three elements of consensus are critical to a fully functioning and useful accountability approach (Usher, 1993a,b). If only outcomes were tracked and reported, it would be impossible to use the information to improve service delivery; that is information and data without context, purpose, and interpretation is useless.

The Outcome Information Components

The Ecology framework maintains that outcome information cannot be used in isolation of information about who is being served and what services are being provided. From this perspective there are three components to the outcome information framework: 1) populations targeted for services; and 2) what services are provided; and 3) information about what outcomes have been achieved.

With respect to answering questions of who is being served, the Ecology framework suggests that tests that two broad categories of information about children and families will be useful in service planning and delivery: 1) information about children and families that makes it possible to determine whether the system serves the children and families it intended to serve; and 2) other information about child and family characteristics that may influence the system's outcomes.

Fundamentally, service providers and other stakeholders need to know that the populations they intend to serve are, in fact, being served. A system which fails to serve its intended population cannot accurately assess its outcomes. In addition to information about target population characteristics, information about other child and family characteristics can be useful in the interpretation of what may have influenced an achieved outcome. Burns (in press) provides a list of suggested child and family characteristics which may influence outcomes. These include risk factors such as poverty, family history of mental illness; illness severity, chronicity and co-morbidity; family strengths and tolerance of stress; social support; family member's case management skills; and treatment adherence by family members and therapists. Combining a limited number of carefully chosen child and family characteristics with information about whether target populations have been served can greatly enhance a system's ability to interpret its outcomes more confidently.

In considering how to describe services that are being provided, the Ecology framework suggests that four aspects are useful for tracking and monitoring services, as well as interpreting future outcome information (Hernandez & Goldman, 1996). These are: 1) intensity, frequency and duration of services; 2) location of services; 3) variety and sequencing of services; and, 4) integrity of services.

This approach requires that planners in organizations articulate, in operational terms, what services they expect to offer. This operationalization and tracking of service aspects gives service systems personnel confidence that the results of their efforts can be plausibly related to the type of services they provide (Dym, 1996). The Ecology framework sees outcome information as a measure of what the system has accomplished. It should be emphasized that the Ecology framework stresses the use of outcomes in the context of managerial needs rather than for purposes of generalizability and application to larger social contexts. It is necessary to establish specific criteria for the selection of outcomes to be measured. The Ecology framework uses a series of questions, shown below, to guide the selection of outcomes.

- Is the outcome information useful to managers and administrators?
- Is the outcome information useful to front-line workers?
- Do the outcome results provide opportunity for corrective action?
- Do the outcome results support the achievement of cultural competence?

Once outcome domains have been selected, a second layer of decision making has to occur in order to select the indicators. That is, decisions must be made as to what indicators will be used to measure the outcomes and what criteria should be applied in making the selection. The Ecology framework offers several questions which may be useful in selecting the indicators. These are shown below:

- Does the indicator adequately represent the status of an outcome?
- Is the indicator easily measured?
- Is the process of data collection and reporting realistic and sustainable?
- Does the indicator provide valid and reliable information about the outcome?

Utilizing the Results

The Ecology framework assumes that using outcome information is a process, not an event (Burns, in press). Two primary elements in the process of utilizing the results rest on this assumption. These elements are 1) the process of interpreting the outcome information, and 2) action decisions made as a result of what has been learned. Figure 2 illustrates that output is produced by the child-serving system in the form of system information regarding who the system has served, what services have been provided, and what outcomes have been produced.

This interpretive process requires returning to the work generated in the Building Blocks component and measuring outcomes against goals that were developed for the service system. The interrelationships among who was served, what services were provided, and what outcomes have resulted must be considered in the interpretive process. Baseline information about all elements at the beginning of the measurement period becomes the reference for understanding the meaning of the information and results.

The focus of the action step is on modifying service planning and delivery, as needed, based on an assessment of the status of the results. This use of the interpretive process to inform a decision to either change or not change aspects of service planning and delivery is best understood as a process of working toward improved results rather than an end result. Rather than a static, one-time process, a system of utilizing the results should be embedded into day-to-day management.

Implications for Children's Mental Health

The shift in interest toward results-based accountability raises hopes that mental health systems will respond more flexibly to those they serve, that public faith in the ability of human service institutions to accomplish their intended purposes will be restored, and that communities will be better able to plan their support of children and families (Schorr et al. 1994). A System of Care for Severely Disturbed Children and Youth (Stroul & Friedman, 1986) more clearly defined the concept of system of care and provided guidance in how to build systems that would allow children to receive services while remaining at home and in their communities. We believe the Ecology of Outcomes framework will both complement and expand the systems of care concept by helping policy makers and administrators establish strategies to build outcome information systems and incorporate outcome information into decisions that impact the planning and delivery of services to children and their families.

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The Development of a Continuous Evaluation System for the Texas Children's Mental Health Plan: Building an Evaluation-Stakeholder Feedback Loop

Lawrence W. Rouse, Ph.D.

Introduction

This summary focuses on the development of an ongoing evaluation system associated with the Texas Children's Mental Health Plan (TCMHP) and the steps taken to build a feedback loop between evaluators and stakeholders. The Texas Children's Mental Health Plan is an interagency effort to develop a continuum of community-based mental health services for children, adolescents, and their families based on the federal Children and Adolescent Services System Program Model (CASSP). The ongoing evaluation was developed in order to provide children's mental health administrators at the state and local level with information about children's mental health services and demonstrate accountability to the consumers and funding sources.

The purpose of this summary is to: (a) explain how outcomes are important to the basic philosophy of TCMHP; (b) describe the system for providing information to stakeholders (e.g., consumers, service providers, program managers, advocates, and legislators); and (c) describe the interactions that have taken place between evaluators and various TCMHP stakeholders in creating an ongoing stream of evaluation information for decision making.

The Texas Children's Mental Health Plan

In 1992, the Texas legislature appropriated monies to the Texas Department of Mental Health and Mental Retardation (TXMHMR) for the implementation of the Texas Children's Mental Health Plan. The primary goal of the TCMHP is to develop and implement a public community-based mental health system for children, adolescents, and their families through the coordination of resources of all the state child-serving agencies. An essential feature of the TCMHP is the participation, at the state and local level, of the child-serving agencies, advocates, and consumers in management teams with the express purpose of making collaborative decisions about TCMHP activities. TCMHP services are organized into three components: (a) "core" mental health services, (b) services to children referred from the juvenile justice system, and (c) early intervention and prevention services. During FY '95, a total of 26,000 children were served through TCMHP services.

Another essential feature of the plan is a list of outcomes to be measured for each of the components of the TCMHP. The outcomes were written into the plan from the very beginning to assure the stakeholders, as well as the state legislature, that the effectiveness of the services were being measured and that decisions about the TCMHP were being assisted by evaluation data. In addition, TXMHMR has been committed to the implementation of the principles of Total Quality Management (TQM) as a work philosophy. One of the hallmarks of the TQM approach is the measurement of work activities, using this information in modifying work processes to increase productivity and effectiveness. Finally, in its shift towards a managed care organizational mode, TXMHMR has recently begun incorporating "outcomes to be attained" in its contracts with each of the community service sites. Therefore, the collection and dissemination of evaluation information to TXMHMR and community site managers is central to the continual development of the TCMHP.

Description of the Evaluation

The development of a continuous evaluation system for the TCMHP was characterized by three stages that began in 1990. The first stage was a summative evaluation of the impact of one main service type on child and family functioning at five mental health centers. In 1992, the evaluation was extended to 16 sites and included the ongoing evaluation of 14 service types. By 1994, the evaluation was implemented at all 45 community mental health authorities across the state. The evaluation currently involves all children served in the public mental health system and 18 service types.

The evaluation is managed by a committee of professional evaluation personnel representing the nine state agencies which participate in the TCMHP, representatives from consumer advocate groups, program directors from the sites, and a parent representing the viewpoint of the consumers.

The basic evaluation design is characterized by pretreatment, post-treatment, and follow-up measurements of consumer demographics, history, outcomes, and satisfaction with services. Outcomes of services include general psychological functioning, behavioral-emotional functioning, out-of-home placement rates, and social-community functioning. A multi-method/multi-rater approach to measurement is employed to collect information from the service providers, children, parents, and collateral providers using interviews, checklists, and rating scales. Data is collected primarily by the service providers at pre-and post-treatment. Follow-up data is collected by the TXMHMR research office.

Communicating evaluation results has been accomplished through the establishment of the Quarterly Service Report, Quarterly Report Review, and special reports. The Quarterly Service Report provides a summary of key indicators in the areas of numbers served, demographics, and outcome measures. The Quarterly Report Review is used as a vehicle for a discussion of the figures on the Quarterly Service Report and also provides an opportunity for the publishing of other evaluation results that may be relevant. Special reports are also produced for TXMHMR center managers and other stakeholders as requested. A catalogue of special reports is maintained and available for reference. Taken together, these publications are seen as an essential tool in facilitating a most important set of evaluation-stakeholder transactions (i.e., a feedback loop).

Evaluator-Stakeholder Feedback Loop

The feedback loop for the TCMHP is characterized by at least four major activities that are constantly being reiterated. The loop begins as stakeholders raise questions about the program. Evaluators collect and analyze data in response to these questions. Evaluators then collaborate with stakeholders in using results, and stakeholders use conclusions about results in making decisions, which lead to new questions, beginning the cycle again.

Within each of these activities, interactions between evaluators and stakeholders provide inertia for the reiteration of the feedback loop. Throughout the development of the TCMHP evaluation, these interactions have contributed to modifications in major activities in order to meet the needs of both the evaluators and the stakeholders.

Stakeholders Raise Initial Questions

The provision of guidelines for evaluation of TCMHP outcomes created an important dialogue between the authors of the plan and the evaluation committee. These interactions established evaluation as part of the plan from the beginning and also helped formulate and clarify the initial evaluation questions. During this process, the evaluation committee voted on specific evaluation questions, methods and measures. As the evaluation progressed, new members were added to the evaluation committee to provide additional guidance.

Collection and Analysis of Data

Perhaps the most attention has been paid to the process for the collection of information and the analysis of data. The original evaluation design included the measurement of outcomes for each service type resulting in several assessments for each child. In order to make the evaluation an integral part of service activity, the design needed to be simplified. Through meetings with groups of service providers and surveys of program directors, it was determined that too much effort was needed to collect multiple assessments, and it was unlikely that clients could distinguish between the different service types. This impression was confirmed through flowcharting of the evaluation process conducted by the evaluation committee. When pictures of the processes and transactions involved in the evaluation were analyzed, a dramatic picture of a complicated and cumbersome flow of activity was revealed. Consequently, a less complex evaluation design was created based on an episode of care.

In order to reduce the burden of data collection on the service providers and provide managers with a minimum set of key outcome indicators, the measures were revised. Program directors were surveyed as to which measures were most meaningful to them. They suggested use of the CBCL and satisfaction forms and elimination of the provider completed pre-and post- treatment assessment forms. Concurrently, the initial measures were reviewed for the frequency of use in data analyses and their psychometric properties. It was discovered that service providers' ratings of treatment plan completion were infrequently used, and subscales of provider completed pre- and post- assessment measures had mixed psychometric properties. Satisfaction forms, however, showed good reliability and validity.

A major effort also was made to integrate the evaluation into preexisting processes to minimize paperwork for service providers while supporting efforts to document compliance with standards. The evaluation was dove-tailed with the Department's efforts to meet defined mental health community standards such as continuity of care, service type descriptions, outcome standards, and client assessment and treatment plan requirements. Additionally, the evaluation utilized the state-wide client registration and assignment data base, thus automating many of the data collection procedures.

Technical assistance to the field was viewed as an essential part of implementation of the evaluation. As a first step, the evaluation committee felt that program directors and service providers would benefit from information on evaluation, data management, and how the state and local computer systems worked. Regional trainings were implemented to introduce the evaluation, followed by on-site evaluation and telephone training. Initially, training was provided to serve providers and program directors. Later, staff from medical records and information services were included. High ratings in five of six training sessions suggested that participants found the sessions to be informative and helpful in implementing work tasks.

As the evaluation proceeded, quality control measures were implemented so the data used in analyses would be credible. The computerized data collection system was edited to force completion of data elements. Additionally, manual editing of data forms was performed and feedback has been given back to the centers. To further assess the accuracy of data, a pilot has been implemented to dovetail with SQA audits.

Special emphasis was placed on empowering staff to make their own decisions about how to implement the evaluation at their own center. Efforts were made to communicate to the staff that the evaluation instructions were often guidelines and they needed to operationalize and consider local needs. For example, on site decision issues included data management and the coordination of data collection tasks with naturally occurring clinical activities. As a result, staff included pre- and post- assessments in intake and discharge activities, and integrated registration and history information into center-specific computer system data entry.

Collaborating with Stakeholders

Evaluators must collaborate with the stakeholders in using the results of evaluation. Managers and service providers need education to read and interpret data from clinical and administrative viewpoints. A service report was created to report data back to stakeholders on a regular basis, presenting data in a tabular fashion. Later, a text was produced to discuss the data, to provide suggestions on what the data meant, as well as how it could be used to monitor programs. Finally, graphic representations of trends were provided.

Surveys were then implemented to determine if the presentation of evaluation information was adequate for the needs of TXMHMR managers and program directors. Results suggested that the service report and accompanying text met their needs. Additionally, informants indicated that preferred elements of evaluation reports included data about outcomes, graphics, and information in a bullet format.

Data about consumer satisfaction was a less frequent preference. In response to this feedback, a new format for the service reports has been developed which features more outcome information. In addition, the increase over time of requests for special data runs demonstrates that stakeholders are finding value in the evaluation process.

Evaluation Results and Program Decisions

If evaluation data are not used in decision making, then the evaluation has not reached its intended goal. Up to this point, the emphasis of the TCMHP has been placed on putting an evaluation system in place. Future activity must measure the extent to which the evaluation data are being used to assist in making program decisions.

Currently, the only measure of the use of evaluation data is anecdotal information such as program directors' reports that the data have been helpful in particular instances. However, there has been increased contact from program directors and TXMHMR managers to request information, and TXMHMR managers have requested that special reports be prepared for legislative aids to support the funding process.

Discussion

The implementation of an ongoing evaluation system for the TCMHP has been a developmental process of implementation and revision, obtaining feedback from external and internal customers and revision again. Establishing interactions with the stakeholders to solve the problems of implementing a continuous evaluation seems best accomplished by starting small and expanding once major issues are identified.

Clearly, the development of an evaluation process has much to offer to the system to be evaluated. In the present situation, the TCMHP evaluation has helped the program directors define the services they are offering and interpret specific aspects of the community standards. It has helped establish outcomes to be included in contract negotiation and monitoring and changed the statewide client data system to be more relevant to children and families served in the system.

Taken together, these experiences and lessons learned seem to indicate that once the initial turn of the feedback loop is accomplished, then further reiterations of the loop are more easily attained.

SumOne for Kids: Measuring and Improving Results in Services for Children and Families

Pamela Meadowcroft, Ph.D.

Introduction

SumOne for Kids is a multi-agency outcome monitoring system developed through a collaboration between The Pressley Ridge Center for Research and Public Policy and 31 private, nonprofit child serving agencies in Pennsylvania. The original goal was to create a system with all technology supports, including functional software, all measurement tools and other data collection devices, training and audit services that was (a) low cost, (b) could be used at the agency or program level for program improvement, (c) would form the basis of a central database that would produce reports useful to policy makers and providers, and (d) would answer the questions: Who are the children and families we serve? What services do they receive at what cost? What is the impact of these services on their lives? To create the central database, all participating agencies would agree to upload a key set of data elements from which aggregate reports would be generated for comparison purposes. In this way, agencies could compare their own results with the combination of all agencies and aggregate reports could better inform policymakers of the results of children's services.

The initial pilot provider agencies served over 5000 children and families every day from all of the major child-serving systems including mental health, child welfare, juvenile justice, and special education. The types of services they provided also represent the full array of services to children and families, including in-home and family preservation services, adoption, day treatment and partial hospital programs, foster family care, therapeutic foster care, group homes, and residential treatment. Therefore, the outcome evaluation system was designed to be useful for all children's services and do-able by provider agency staff.

The following are some of the lessons learned and values developed from the mistakes we made and the barriers we experienced in creating SumOne for Kids.

Lesson 1

The first rule of comedy, politics, and sex, and now outcome measurement, is that timing is everything. The original start-up for SumOne for Kids six years ago was painfully slow. Funding was not immediately available since the Foundation community at that time did not view outcome evaluation to be an urgent priority. Nor did the payers of children's services view measurement of outcomes as a necessity. For example, for eight years the results of the direct services programs at Pressley Ridge had been evaluated by contacting the few hundred children and families whose services had been completed the year before. This follow-up evaluation served as the prototype for SumOne for Kids and provided Pressley Ridge management, clinicians, and the board of trustees with a way of focusing priorities for each year's program development activities. However, not once in the eight years did the agency's referral of funding sources ask for or use the outcome results. Such disinterest has dramatically changed in the last two years. The pace and subsequent funding and interest in outcome evaluation in general, and SumOne for Kids in particular, has exploded.

Lesson 2

Build on what the users of the outcome monitoring system are already doing. SumOne for Kids staff take participating agencies through a design process that builds on what they are already collecting. The original pilot group of agencies helped determine all of the data elements that fully describe the children and families served and the types of services received. In replications, this same customizing process is used to ensure that participating groups have input into the data that is required by the outcome system. The pilot agencies also fully tested the outcome interviews that were developed, the forms that were used to catch the data elements, and the initial software.

Lesson 3

Make the data useful and easy to get. Most provider agencies already collect lots of data. But the data are only useful when (a) it is in a readily retrievable, readable form (i.e. attractive, easy to read reports); and, (b) when it can be compared to benchmarks so the results have meaning. SumOne for Kids built into the software standardized reports that the pilot agencies tell us are essential for the day to day operating of their services. The standard reports were designed and tested to be readable by nonresearch staff; hence, agencies can use the reports without research staff.

Lesson 4

There must be a strong incentive for agencies/systems to become accountable. The impetus for SumOne for Kids came in 1989 when it began to look as if a system of accountability might be imposed on Pennsylvania providers by the legislature. The provider agencies decided to be pro-active, develop their own system, and then turn it over to the state for use as a state-imposed monitoring system (bottom-up/top down approach). While SumOne for Kids is based on self-evaluation assumptions in which agencies want to know how effective their services are, outcome monitoring will require mandates in some form to insure the level of commitment required of agencies to produce accurate, timely data. Only recently has Pennsylvania begun to mandate outcome evaluation in different forms. For example, in Allegheny County, outcome evaluation is now part of the contracting process with all Children and Youth Services providers.

Lesson 5

Get political support early on and throughout the development and implementation of any outcome monitoring system. An outcome monitoring system may be technically valid and sophisticated, but not at all useful if it does not have widespread political support. When SumOne for Kids began, a group of bureaucrats, policy makers, educators, researchers, and practitioners was assembled for the purpose of articulating a vision of what such a system might look like and how it might operate. Everyone present gave high praise to the concept, pledged the full support of their offices, and asked to be kept informed of project status. The same process has been used even more successfully in Maryland, where there are no regulatory requirements for program evaluation in residential services.

Lesson 6

"Outcomes" lack clear definition. Although outcomes are now talked about by persons at a variety of levels and in many kinds of systems, there is little agreement on what they are. Practitioners are interested in clinical outcomes that relate to the child's treatment plan. Program managers and states are more often interested in process measures, such as numbers of service units provided, or number of children served, and will consider these the "outcomes" of importance. Project staff, however, took a stand early-on that we would look at socially significant impacts of the services provided on the lives of children and families served. Such functional outcomes can appeal to the practitioner, program manager, as well as state level policy-makers.

To assess functional outcomes requires a commitment to looking at the results of services after receipt of these services. Project staff found numerous barriers to this view of outcome measurement. Many providers believe their accountability ends when the child leaves their program. Others feel that post-discharge results can be useful in determining program change, but there is no agreement on how long after discharge that responsibility lasts. The project decided to ask a large group of varied children's services stakeholders to define outcomes for us, thus avoiding having to debate the outcomes definition with evaluation experts or anxious providers.

Lesson 7

Involve stakeholders in key aspects of developing outcome measures. This lesson, as all the others, was learned over and over again. A large-scale social validation survey of over 700 Pennsylvania stakeholders of children's services defined the outcome indicators for us. (This survey was reported at the Research Conference in 1992.) The survey asked respondents to indicate how important various issues were to them and how satisfied they were with the services available in their community to address those issues. With a

90% response rate, project staff felt they had solid evidence of what issues should be put forward as the most important ones to measure, which were:

- stability and restrictiveness of children's living environments;
- use of drugs and alcohol;
- school attendance and graduation;
- employment and job readiness; and
- protection from harm.

The 31 pilot agencies provided SumOne for Kids staff with the sites to test out the various tools that were designed to measure the above outcome indicators. A similar stakeholder survey was conducted in Maryland with over 1000 participants. The results bore a striking similarity to that of the Pennsylvania survey.

Lesson 8

Generate products quickly and keep the momentum active or participants will lose interest, at best. A certain momentum must be achieved and maintained to keep participants involved, and there needs to be regular communication between project staff and its participants. Newsletters, reports on results of each project step, getting part of the data system operating and producing results right away are some of the tactics project staff learned along the way to keep project participants interested. Dispose of research methods that are time-consuming and opt for ones that, while less rigorous, will produce reasonably valid results with less time.

Lesson 9

Willima of Ochen of the middle ages gave us this lesson: "keep it as simple as possible, but no simpler." SumOne for Kids aimed to create a "simple" product&endash;one that was useful and easy to use. The final product is far bigger than originally thought necessary. It was perhaps inevitable because this first-of-its-kind product used a consensus model involving over 31 agencies and other stakeholders in the design and development. The first "final" product (which includes a comprehensive database on describing the children and families served, services received, and results produced in five major functional outcome areas) has been met with enthusiasm by those who have used it but with concerns by those who see it as too much. Our interaction with others who are developing outcome measurement systems indicates that the move to complex is quicker than the move to elegant simplicity. Future developments will be a balance of adding more to the system (such as "protective factors" and eliminating complicated protocols and unused data.

Discussion

The project proved sufficiently successful to be spun-off into a separate corporation called the Corporation for Standards and Outcomes (CS&O). CS&O is now replicating and improving upon SumOne for Kids in Maryland through the Maryland association of 65 child-serving agencies in that state and has made participation in SumOne for Kids mandatory for agency members. Given the multi-agency, multiple systems represented by these provider agencies, and statewide nature of the SumOne for Kids outcome measurement system, staff believe that the results will ultimately have a powerful impact on children's services in Pennsylvania and Maryland.

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Building Outcome Accountability in Children's Mental Health: Interviews with Center for Mental Health Services Grantees

Authors

Introduction Methodology Results Conclusions

Introduction

The *Building Outcome Accountability in Children's Mental Health* project was an effort to learn more about how each of the twenty-two Center for Mental Health Services (CMHS) grantees were conceptualizing and implementing a local process of outcome evaluation. This study was conducted as part of the System Accountability Study, a 5-year research effort of the Research and Training Center for Children's Mental Health (RTC) designed to investigate the impact that utilizing measurable outcomes has on service systems.

The Building Outcome Accountability project focused on the conceptualization and implementation of outcome-based information systems at the twenty-two CMHS sites. These sites received grants designed to promote the development of systems of care that include mental health, child welfare, education, juvenile justice, and other appropriate agencies to meet the multiple and changing needs of children and adolescents and their families. A related activity, the core evaluation of the CMHS initiative, conducted by Macro International, Inc. and its partner, the University of South Florida, is focused on the child, the system, and the interaction between the two. The Building Outcome Accountability project focused on how outcome results were being used in CMHS systems of care in a effort to understand how using measurable outcome data affects service planning and delivery.

Methodology

The data for the Building Outcome Accountability project were collected through a series of structured key informant telephone interviews with employees at each of the CMHS sites. Two interview protocols were developed for this research project: 1) Survey A, designed for sites with established outcome information systems; and 2) Survey B, designed for sites which had not yet established outcome information system. Each site determined who would participate in the interview and whether Survey A or Survey B would be completed.

Both survey instruments asked participants to comment on the array of services offered by their system of care, how and when the system of care was established, and demographic information about the population served. Both surveys also asked participants to comment on the involvement of stakeholders in the process of selecting outcomes to be tracked and the impact of outcome tracking on service planning and delivery. In addition, systems which identified themselves as having established outcome tracking systems were asked to comment on what kinds of outcomes were tracked, how often they are tracked, how these outcomes are measured, and the level of interagency collaboration required to monitor outcomes. They were also asked to discuss how outcome information is being reported, who receives these reports, and how it is being used. Finally, respondents that completed the survey questions for sites with an established outcome information system were asked to comment on the continued use of outcome data when the national evaluation is completed.

The interviews for this project were conducted during a five-month period beginning October 1995 and ending in February 1996. Nineteen out of the twenty-two grantee sites (86%) participated in the interview process. All participants were advised that the results of this study would be reported in aggregated form and that the identities of individual systems of care and respondents would remain anonymous. Ten of the respondents (53%) represented sites with an established outcome information system, while nine participating sites (47%) did not have such a system established.

Results

The data was analyzed across three domains: 1) stakeholder involvement in selecting outcomes; 2) the impact of outcomes on service planning and delivery; and 3) using outcomes when the national evaluation is completed. The results are discussed below.

Stakeholder Involvement

Participants were asked to rate the importance of stakeholder involvement on a Likert-type scale from 1- *not* stakeholder involvement on a Likert-type scale from 1- *not important at all* to 5- *crucial*. All but one of the participating sites considered stakeholder involvement in the process of selecting outcomes to be very important or higher. The single site not responding in this range reported that they chose not to respond, believing it to be irrelevant to their situation because they had uniformly adopted the outcome measures currently being used in the national evaluation. While nineteen sites considered stakeholder involvement important to the process of selecting outcomes, 5 sites (one site which considered stakeholder involvement *very important* and four which considered it *crucial*) reported having no vehicle currently developed to facilitate this involvement. One respondent commented that there is no systematic way of involving stakeholders at this time, although they anticipated doing so in the future. Another commented that there is a "growing discussion of how stakeholders can be involved." These results imply that while almost all of the respondents thought stakeholder involvement was important, some sites (26%) had no mechanism for achieving this goal. This indicates that agreement with the principle does not always equate to implementation.

Impact on Service Planning and Delivery

Nineteen of the twenty participants in this study chose to answer the series of questions relating to the impact of outcome tracking on service planning and delivery. One site declined because they believed there was not yet enough outcome data available yet to comment. Respondents were asked to rank the impact of outcome tracking&endash;anticipated or actual&endash;on service planning and service delivery on a Likert-type scale of 1- *no impact* to 5 - *tremendous impact*. Ten participants (53%) responded that the impact on services planning was *tremendous*, eight responded the impact was 4 - *considerable*, and one responded outcome tracking had 3 - *some* impact. The ten sites which rated the impact of outcomes on service planning as *tremendous* also believed the impact of outcome tracking on service delivery to be *tremendous*. Of the remaining nine sites, six rated the impact of outcomes on service delivery as *considerable*, and three believed outcomes would have *some* impact on service planning.

A common concern expressed by respondents was for the burden and consequent stress that the process of establishing a system of outcome information places on management and staff. One respondent commented, "Putting an outcome system in place can be painful because of the procedural changes, increases in paperwork, and increased need for management and staff training." Other respondents echoed this statement. Concern was expressed that, "outcome tracking adds paperwork and takes time away from actual service provision." Another commented that "tracking outcomes requires ongoing training and technical assistance on how to and why outcomes are collected. People are intimidated by data and forms. You must keep reinforcing intimidated by data and forms. You must keep reinforcing the process."

The experience of staff at CMHS sites which have established outcome information systems indicates that the stress and burden of implementation may be a short-term concern. One respondent discussed the short term impact: "Service providers are heavily impacted by the demands of the outcome process. It is difficult to implement in the short-run because the most immediate impact is that clinicians are overwhelmed by the process." According to some respondents, however, once outcome information becomes available, stress-levels are reduced.

Several respondents expressed concern for fears associated with how outcome information is used. One respondent stated, "there exists a real fear on the part of clinicians that outcomes will be used to demonstrate they are not doing a good job &endash; what if we're not doing well?" There was consensus that training was an important way to promote understanding of how outcomes can be used in a positive way to improve service delivery.

Continuation of Outcome Monitoring

Respondents representing the ten sites with established outcome information systems were asked a series of questions about whether, and under what circumstances, they might continue tracking outcome information after completion of the national evaluation. All ten responded that they anticipate continuing the process of outcome monitoring, although the strength of the replies ranged from "Yes, hopefully, it depends on available funding" to "Yes, definitely, outcomes very similar to the national evaluation are included in our state plan." When asked to identify factors that would influence the decision to continue outcome tracking, it is noteworthy that eight of the ten sites mentioned available funding as the central deciding factor.

Conclusions

It was recognized early in the development of the interview instruments used in this project that there would be variation among the CMHS grantees in the degree to which their systems of care had been conceptualized and implemented, as well as the degree to which their information accountability systems were developed. The amount of overlap between the level of development of the service system and the outcome information system seemed to have an impact on how outcome information is used by the system of care (see Figure 1). This can be seen in how information about clinical outcome measures is used. Descriptions of three example sites follow to illustrate varying degrees of overlap between the level of development of the service systems and the accountability systems in this study.

A respondent whose system of care began developing

A respondent whose system of care began developing within the past few years reports that the site is also just beginning to collect outcome information. This site respondent indicates that the system does not have a vehicle for involving stakeholders in decisions regarding outcomes at this time. Interagency collaboration at the site occurs only at the direct-service level where interagency teams serve individual children and their families. Although this respondent noted that the "CAFAS [Child and Adolescent Functional Assessment Scale] is an excellent measure," staff are still struggling with trying to determine what outcomes they need to track and how to use the results. This system seems to represent a situation in which the service system and the outcome accountability system are both developing in parallel and exist independently of one another at this point in time.

Another grantee in the early stages of system development describes their system as having "lots of pieces for the past eight or so years, but we only recently began building an integrated system." This respondent describes the site as relying heavily on the input of a broad range of stakeholders as it expands its array of services. Also, interagency relationships are growing in strength and he/she believes that "to take a systems point of view, we need to know what our connection with other systems is." This respondent reports that the site is already using clinical data to make decisions at the treatment level, but does not yet have a way of using this information at a program or system level. This site represents a system at the early stages of both system and information development. Some degree of overlap in the development of the services offered and the information system seems to be indicated by the use of clinical outcome data to inform treatment at the child and family level.

In contrast to the previous examples, one of the more developed systems of care sites has already focused on potential uses for outcome results or information at the system level. The respondent for this site reported that its system of care had been developed for more than ten years, and it had been measuring and reporting outcome information for several years. The initial outcomes tracked through the system of care were more global; for example, emphasis was placed on system level measures such as out-of home placements, school attendance and achievement, and juvenile justice recidivism rather than clinical measures. Discussions at the site concerning different aspects of the information system focused on issues of sharing information across the system, such as creating electronically connected information systems to lower technical boundaries so that outcome data could be accessed. This site's focus on clinical outcome measures went beyond their use at a child level/direct service level to recognition of how clinical status information might be used to learn more about how effectively the system is functioning. This site seems to represent a system of care which is well developed with an information system which is well established. In addition, there seems to be a high degree of overlap between the system of services and the information system. This takes place through its efforts to create a seamless source of interagency information and its interest in using clinical outcome information to evaluate system effectiveness in addition to informing treatment decisions.

In conclusion, the CMHS sites represent varying degrees of both systems development outcome accountability development. For outcomes to have a maximum positive impact on service planning and delivery, it may be necessary for there to be a high degree of overlap between the service system and the information system. The data collected in this study illustrate a range of overlap from a service system which seems to exist independently of the information system being developed to support it, to one which seems to have a high degree of overlap, as evidenced by the multiple uses of clinical outcome measures for informing service planning and delivery.

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A Comparison of the Standards for the Mental Health Statistics Improvement Project (MHSIP) with Selected Children's Information Systems

Authors

Introduction Method Results Discussion References

Introduction

Mental health decision makers need comprehensive, uniform data in order to conduct analysis and planning on the national and state levels. A major initiative to promote uniform mental health data began in 1989 when the federally funded Mental Health Statistics Improvement Project (MHSIP) defined a set of standard data elements recommended for mental health information systems (NIMH, 1989). Following the publication of the MHSIP standards, the Task Force on Enhancing MHSIP to Meet the Needs of Children and Youth in 1992 recommended additional MHSIP data elements specific to children's mental health.

States are still struggling to fully implement MHSIP standards in their mental health information systems. One of the obstacles seems to be a perceived conflict or competition between agency information systems' priorities and the requirements of the MHSIP standards.

Agency managers' top priority is to have a system that provides data for management of clients and programs. In addition, they periodically need specific data to respond to evaluation inquiries. If evaluation data are not available, then special data collections have to be carried out to meet each data request. If collecting the information to meet either of these goals appears to conflict with implementing the MHSIP standards, agency needs often take priority over the MHSIP standards.

An additional obstacle can arise when mental health agencies wish to share data with external multi-agency children's data bases. This requires the mental health agency to have the appropriate data in a format acceptable to other agencies. The value of sharing data with larger data bases may be perceived to supersede the importance of meeting MHSIP standards.

If children's mental health administrators perceive the MHSIP standards to be an additional burden that uses resources they would rather be using to meet important data needs, then MHSIP will not be implemented. We all recognize that no information system will be able to meet every need, but the ideal is a system that provides as much of the necessary data as possible so that special data collections are rare.

The purpose of this study was to examine the extent to which children's mental health agencies can meet the information needs they consider the most important and still support the MHSIP standards. Since the focus of the study was on agency information decisions, the data sources and study questions were selected to reflect real life situations.

Method

Three children's data sets were selected for this analysis to represent three different agency information priorities:

- An information system for client and program management to represent the data needs for agency management.
- The data set for a national children's mental health program evaluation to identify typical evaluation data needs.
- A social service agency data set for children involved in foster care and adoption to illustrate the data needs of a different type of child-serving agency.

The analysis used real life scenarios, with the questions framed from the point of view of an agency administrator making decisions about information systems. Each question asked if an agency had an information system designed to meet one purpose, what alterations would be required to expand the system to meet an additional purpose.

- If a children's mental health agency has an information system that meets their management needs, what changes would have to be made for the system to also meet MHSIP standards?
- If an mental health agency has an information system that meets MHSIP standards, what changes would be needed for it to also provide evaluation data?
- If a social service agency is developing a foster care and adoption information system, what changes would a mental health agency have to make for the system also to meet MHSIP standards?

In order to compare the data elements across systems, the client and event data elements in the MHSIP standards and the selected data sets were subdivided into the following domains: (a) Program Information, (b) Client Demographics, (c) Family Structure/Placement, (d) Referral, (e) Health/Mental Health Status, (f) Plan of Care, and (g) Outcomes. Program Information included record and (g) Outcomes. Program Information included record number, state of residence, and dates of client's enrollment or discharge from the program. Client Demographics contained basic client demographic elements such as name, social security number, sex, race, and insurance. Family Structure/Placement included information on current and historical family structures &endash; including birth parents, foster and adoptive parents, and other caretakers &endash; as well as placement information. Referral included information about referral source, intake, previous involvement of other agencies and presenting problem. Health/Mental Health Status captured assessment tools and other indicators of health and functioning including school placement. Plan of Care addressed services information and multi-agency involvement, and Outcomes included indicators of client status over time and at termination from the program.

Results

This study found that the MHSIP standards were very compatible with mental health agency needs for program and client management data, as well as with needs for evaluation data. In addition, when agencies wish to merge their data into larger children's data bases outside the agency, with the exception of data elements specific to mental health operations, a high degree of compatibility between these data bases and the MHSIP standards can be expected. More specifically, the analysis suggests:

- Agencies with typical management information systems should be able to meet MHSIP standards with minimal effort.
- MHSIP-based agency information systems show substantial agreement with a typical evaluation data set except for some missing data elements in the domains of Family Structure/Placement and Outcomes
- In spite of the differences in their missions and purposes, social service agency data bases contain a substantial number of the same data elements as children's mental health data bases, with only the data elements specific to the mental health activity missing.

Discussion

Children's mental health agencies attempt to be part of several worlds. Within the comprehensive mental health system, they need to cooperate with the data collection and reporting strategies of that system. As part of a total system of care for children, they need to cooperate in data sharing with the other agencies and partners who serve children and families. While trying to accommodate the needs of both of these complex systems, they need to manage the programs and clients for which they are responsible and regularly respond to internal reporting and evaluation needs.

Achieving an information system that specifically meets each of these demands, and yet is flexible enough to accommodate all of them, is challenging. This analysis found that there is a high level of overlap in data elements across systems representing each of the requirements. Therefore, designing a system which will meet several of the needs, or alternatively expanding an existing system to accommodate new purposes, need not be an insurmountable task.

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Chapter 4

Evaluating Wraparound Services

Symposium

Establishing Wraparound Fidelity: Not Business as Usual

Authors

Not Business as Usual: Establishing Wraparound Fidelity

Deciphering the Tower of Babel

Establishing Wraparound Fidelity Through Participatory Evaluation

Preliminary Outcomes of a School-based Wraparound Program

Not Business as Usual: Establishing Wraparound Fidelity

Failure to ground the wraparound model in more than value-based philosophic principles is leading to its adaptation as another form of case management by professionals whose training and experience has been in expert models of deficit remediation. These models limit the decision-making voice of families while ignoring or failing to utilize their perspectives and strengths. The following summaries describe thirty months of participatory program evaluation and simultaneous program development between the University of South Florida's Child and Family Policy Program and a mental health-supported, elementary school-based program in Tampa, FL. and begin to address the critical question of fidelity of intervention and its relationship to outcomes for children and their families.

The Joint Venture Family School Support Team (FASST) implemented a "family-centered, strengths-based" approach which they called wraparound. However, key informant interviews conducted in November, 1993 with eight policy makers from the Hillsborough County Public Schools and the Children's Board of Hillsborough County indicated that many lessons learned from the Ventura Project (Jordan & Hernandez, 1990) had not been applied. There appeared to be no agreement on target population, no consensus on desired system change, and no common understanding of the wraparound model implemented through the FASST program. These summaries describe how simultaneous, participatory processes of evaluation and program participatory processes of evaluation and program development defined the wraparound model, measured outcomes, and identified elements of program policy, management, and practice that were undermining the integrity of the intervention.

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Deciphering the Tower of Babel: Preliminary Steps Toward Establishing a Theory Base for Wraparound Fidelity

Rosalyn Malysiak, Ph.D.

Introduction

Multiple theories, methodologies, and confused terminology rooted in different paradigms of thought have contributed to an inadequate service structure in which professionals utilize medically driven models as the perceptual prism to define families of children with serious emotional disturbance as dysfunctional. European in origin, a North American alternative to this expert model is emerging which has been loosely termed "wraparound process," and which has coalesced around a broadly stated, strengths-based and family-centered ecological approach, emphasizing individualized service and treatment in the most appropriate and least restrictive setting (Boyd, 1991; Burchard & Clarke, 1990; Duchnowski & Friedman, 1990; VanDenBerg & Grealish, 1996).

Applications of wraparound are now emerging from an early developmental stage in which it has been defined through value-based, philosophic principles that begin to differentiate it from the professionally driven process characteristic of more traditional forms of family-centered practice. However, the maturation of wraparound is threatened by a developmental paradox. Those who have been trained in the old theories of assessment and remediation of deficit, and whose careers have been shaped by the professionally driven process of traditional service models, must play transformative roles in the emergence of this promising alternative. This potential conflict is exacerbated by, and echoes through, a "Tower of Babel" of terminology used to describe seemingly similar approaches to working with children and their families. Amidst this confusion, the value-based principles which have guided wraparound have all too often been misinterpreted and misapplied as emergent case management methodology.

This essential change from categorical to integrated and individualized services, and from deficit assessment by professionals to a process of ecological strengths enhancement which engages families as decision-making enhancement which engages families as decision-making participants, has occurred without articulation of its implicit roots in constructivist and critical thought, nor of its slightly more explicit basis in ecological systems theory. This summary presents initial data from a case study design (Yin, 1989; 1994) which evaluated, as a basis for wraparound fidelity, a single construct and operative focus: families acting as decision making participants in a process of ecological strengths enhancement.

This descriptive, exploratory study generalized to theory, not to a population. It contended that when consciously applied in tandem, elements of this construct anchor the wraparound process in its implicit basis of constructivist and critical thought and ecological systems theory. Without their application from this basis, the wraparound process reverts toward professionally driven and deficit-focused efforts typical of more traditional forms of family-centered practice. Cases in this study were defined as all participants in the development and implementation of family support plans in the FASST program. Seven cases, opened in October and November, 1995, formed the basis for the study which focused through experiences of participants in the purposively sampled cases.

A critical review of the literature focused on the social and paradigmatic emergence and transformation of family systems theory and the related development and transformation of family-centered practice through a wide range of disciplines. This review differentiated and operationalized five levels of family-centered practice as focused through the complimentarity of family and professional roles and their use of strengths in support planning and implementation (see Table 1). The first three levels reflected more traditional forms of family-centered practice within expert models which focused upon deficit remediation. Levels four and five described when families acted as decision making participants in a process of ecological strengths enhancement, the posited basis for wraparound fidelity as a collaborative model of family-centered practice.

Method

Two opposing sets of a priori propositions were derived from the review of the literature, and from these, operational definitions of family-centered practice were applied in this study. These propositions described and assessed the presence of elements of these two models in the seven cases through three methods of data collection at different points in the development and implementation of the wraparound plans. The patterns which emerged at the conclusion of the study in May, 1996 addressed the research question: "When families act as decision making participants in a process of ecological strengths enhancement, how do applications of wraparound, a collaborative model, differ from family-centered practice within the expert model?" The propositions tested for wraparound fidelity as a propositions tested for wraparound fidelity as a collaborative model of family-centered practice were:

- Families will act as participants of a community team in which assessment and implementation decisions are reached by consensus. When consensus cannot be reached, the team will value and abide by the decision of the family.
- Community participants will share their expertise and perspective in a way which provides information as well as access to service while respecting the families' perspectives.
- Families will have sufficient information as well as access to services to voice their perspectives, strengths, and needs.
- Decisions made by this team will recognize and combine the strengths of the family with the strengths in the community, including the more traditional service structure.
- The combined ecological and family strengths will be the basis for individualized activities which target specific needs.

Propositions tested for family-centered practice within an expert model were:

- Families will provide information to professionals who assess problems or needs and who then attempt to remedy them by matching each to an existing service.
- Community participants will present their perspective and expertise in a manner which limits the role of the family as an equal decision making participant and which does not respect the family's perspective.
- Services delivered to the family will not reflect the family's perspective of what might best meet their needs.
- If strengths are identified, they will primarily be within the family, and they will not be actively and overtly utilized to meet identified needs.
- Activities in the family support plans will not overtly seek to combine strengths of the family with strengths in the community.

The study employed a multi-method, multi-source approach with three primary sources or waves of data: (a) systematic observation of community team meetings in which issues and perspectives were explored with referred families, and in which the family support plan was developed (October & November, 1995); (b) semi-structured interviews with family support plan participants involved in the seven cases under study (January through March, 1996; n = 44); and (c) systematic review of the formal FASST case files. Based on the initial analysis of the first wave of data, three cases were assigned to a collaborative model cell. This meant that at assessment and planning, the process between family members and other participants appeared to fit operational definitions 4 or 5 of family-centered practice, the posited basis for wraparound fidelity (see Table 1). Four cases were basis for wraparound fidelity (see Table 1). Four cases were assigned to an expert model cell because coding indicated that assessment and planning appeared within operational definitions 1, 2, or 3 of family-centered practice (see Table 1).

On a case by case basis, wave 2 semi-structured interviews would be analyzed and coded for evidence of all propositions, while the systematic review of FASST case files in Wave 3 would be utilized to corroborate, disconfirm, or enrich data which emerged from the first two sources. Through this within-case analysis, movement from one cell at assessment and planning toward the other cell during implementation could be documented. This multi-source, multi-method design would be utilized to develop converging lines of inquiry through identification of pattern convergence or divergence through triangulation or replication in all waves of data. Patterns between cases in the same cell would be examined in similar manner in an iterative process to develop converging lines of inquiry to delimit multiple explanations or to uncover a few explanations which would hold under predictable situations.

Study Implications

The final level of analysis of between cell patterns would be compared and contrasted to answer the research question: "When families act as decision making participants in a process of ecological strengths enhancement, how do applications of wraparound, a collaborative model, differ from family-centered practice within the expert model?" The answers to this question will begin to establish a theory and paradigm basis which may better ensure fidelity than the easily misinterpreted value-based principles which currently define wraparound. This will provide a preliminary and essential step toward promoting the integrity of wraparound applications. As such, it may provide greater clarity in conceptualizing frameworks for more successful collaboration between families, schools, and communities as well as provide a foundation and means for process evaluations and program development of wraparound initiatives. By developing a foundation and means for ensuring wraparound fidelity, outcome evaluations, cost-benefit analysis, and surveys of participant satisfaction could be more meaningfully compared with more traditional forms of family-centered practice and service delivery to better guide policy and funding decisions. Final results from this study will be forthcoming.

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Establishing Wraparound Fidelity Through Participatory Evaluation

Rosalyn Malysiak, Ph.D., Al Duchnowski, Ph.D., Marcia Black, M.S.W., & Michael Greeson

Evaluation of treatment fidelity in the implementation of a wraparound approach has presented a challenge to the field of children's mental health services. This challenge is due, in large part, to the lack of an articulated theory that can offer constructs to better anchor practice within this promising model Without demonstrated fidelity, program evaluations produce confused and sometimes disheartening results.

This summary, along with two others, addresses the evaluation of the Joint Venture Family School Support Team (FASST), an emerging school-based program in Tampa, FL that employed a wraparound approach. FASST's target population was children who had received or were at risk of receiving a diagnosis for emotional or behavioral disturbance. The program was implemented by two mental health centers who shared responsibility in the program and delivered service through six elementary schools in a predominately low income area of Tampa. It was guided by a manager, and each school had a team composed of a family support coordinator and a paraprofessional family advocate who had a child attending that school. These two staff members met with referred families to develop initial support plans which were brought to a standing community team that met on a monthly basis for refinement and review of the plans.

The FASST program began operations in the fall of 1993 with a new and relatively inexperienced staff who received traditional mental health in-service training, as well as some exposure to interpretations of the value-based philosophy of the wraparound approach. Soon thereafter, doctoral students and the director of the University of South Florida's Child and the director of the University of South Florida's Child and Family Policy Program began a process of participatory research and evaluation which guided program development.

Initial participant observations of the community team meetings as well as program staff meetings had shown that well-intentioned, enthusiastic family support coordinators and family advocates were highly confused and pulled in different directions by the multiple perspectives and actions of school, mental health, and social service system participants in the wraparound plans. Roles in the program were not well defined, and the process enacted with families appeared, at best, like team case management within an expert, medically driven model.

To develop a common base of operations, USF doctoral students, acting as consultants, led program staff through a participatory evaluation of their roles and the program which asked three deceivingly simple questions: (a) What worked? (Best Practice); (b) What didn't work? (Barriers to Best Practice); and (c) What did they need to make the program work better? The answers to these questions guided subsequent program development. What was working was combined with staff suggestions for improvements, and approaches to address the barriers to best practice. This was a consciously constructed isomorphic process of participatory evaluation and planning which mimicked the evocation of multiple perspectives, the development of consensus, and the combining of strengths to meet needs which occurs in a wraparound approach.

By the end of the fall of 1994, FASST staff had requested and received considerable support in developing strengths-needs based wraparound plans, as well as in how to engage families as decision-making participants. Combining this support with what they felt were the strengths within their program, FASST staff then identified that the standing community teams were themselves undermining the integrity of a wraparound approach. Each community team had representatives from the school, mental health, and social service agencies who brought their professional expertise to the development and review of the family support plans in a manner which often failed to acknowledge or utilize the perspectives and strengths of the family, and limited the family role primarily to one of informant and recipient of service. Plans which emerged from these teams typically identified needs solely in the family and matched them to existing services.

Facilitated by the USF consultants in the winter of 1995, FASST staff developed a questionnaire to assess the community team members' understanding of the roles of participants and process within a wraparound approach. The questions focused on a key construct, with its operative focus which was in the process of development by one of the consultants to use as the basis for conceptualizing and testing a theory base for wraparound fidelity: Families

testing a theory base for wraparound fidelity: Families acting as decision-making participants in a process of ecological strengths-needs based planning and implementation.

Survey results from 41 of 60 possible respondents were reviewed by the entire FASST staff over a period of one month in a participatory process facilitated by the USF consultants. This participatory approach appeared to enhance staff cohesion and understanding of the key construct which differentiates wraparound as an emerging collaborative model of family-centered practice from more traditional family-centered practice within expert models of deficit remediation. However, results indicated that professionals on these community teams had difficulty transcending the formal training they had received in deficit theories and the expert model of practice. Though these professionals articulated a role for families as "partners," during the planning and implementation, they primarily relegated families to roles of informant and recipient of service recommended by the team. The slippage into the expert model was further revealed by the FASST staff's rating these responses on a scale measuring strengths-based planning that placed the community team members solidly within a deficit remediation focus typical of more traditional forms of family-centered practice.

These results were used in another participatory process facilitated by USF consultants in which FASST staff developed a program brochure which described the intended roles of families and professionals in a process of ecological strengths-needs based assessment and implementation. Subsequent outcome and process evaluations were conducted and are reported in the following section.

Preliminary Outcomes of a School-based Wraparound Program

Norin Dollard, M.P.A. & Robert Slewzckowski, M.A.

The Joint Venture Family and School Support Teams (FASST) serves children identified as having or at-risk of emotional and behavioral disorders and their families. Through a team planning process, a Family Support Plan is developed which guides the Family Coordinators and Family Advocates in assisting families to attain the goals they have set for their themselves at home, in school, and in the community. The composition of teams, which includes parents, school personnel, and community agency representatives, is intended to foster consideration of the family's strengths across the ecology of the family system in the development of this plan.

The funding of this project requires that descriptions of the children and families served, the services provided, and assessed outcomes are reported. While these data serve an important function (i.e., reporting to the funding organizations and developing the "habit" of systematic data organizations and developing the "habit" of systematic data collection for program staff), data collection efforts were not primarily focused on supporting development at the program or clinical level. Consistent with the participatory approach taken to the development of an ecological strengths-enhancement among staffing team members, doctoral students worked with the program staff to clarify ways in which data could support program development. Three target areas were identified for enhanced assessment: (a) description of children enrolled, (b) analysis of service delivery and utilization patterns, and (c) outcomes of children enrolled in FASST.

Description of Children Served

Part of the efforts of the FASST program staff and university staff led to incorporation of standardized measures into the intake and case review process to inform clinical decision making as well as to serve the evaluation needs of the program. In the future, data for all children enrolled in the program at enrollment, six months, and discharge will be available. These procedures were not fully in place at the end of the second year of program operation, hence the smaller number of children for whom data is available.

While 103 children received services in the 1995-6 fiscal year, including 49 children who were enrolled in this time frame, the present report is limited to discussion of those children who received at least six months of services (N = 51). The majority of these children were white non-Hispanic (55%) males (78%). At the time of the initial staffing, the largest group of children served was in the first grade (21.6%), as is consistent with FASST's preventative focus. However, a large proportion were in the fourth (17.6%), fifth (19.6%), and sixth grades (11.8%). Most of the children (79%) received free or reduced lunch rates that serve as an indication of low income levels for these families. Although many of the children in FASST are identified for special education services, only 20% are being served in settings for those identified as having emotional handicaps or serious emotional disturbance. Furthermore, their attendance is of concern, with the average student missing over three weeks of school (16.2 days, range 0-55 days) in the year before enrollment in FASST.

The children enrolled in FASST present with some very challenging behaviors and functional impairments, both at home and in school. Parents (64%) most commonly identify externalizing behaviors as being an impetus for referral. Similarly, school personnel identify non-compliant behavior (62%) as the most frequent reason for referral, but academic risk factors, such as being below grade level (42%) are also considered in referring a child. These risk factors also are documented in standardized measures completed by parents, teachers, and Family Coordinators.

To obtain an idea of problem behaviors exhibited at home and in school, parents were asked to complete the Child Behavior Checklist (CBCL; Achenbach, 1991a). Teachers provided similar information about the child's school behavior by completing the Teacher Report Form (TRF; Achenbach, 1991b). The results showed that both parents and teachers identified approximately two-thirds as falling in the clinical range on the Total Problem T-Score, an indicator of global functioning (see Figure 1). Consistent with the behaviors reported in the referring information, the majority of children displayed externalizing behaviors both at home and in school. Substantial proportions, however, also scored in the clinical range on the Internalizing T-scores.

To ensure multiple perspectives of a child's level of functioning, Family Coordinators completed the Child and Adolescent Functional Assessment Scales (CAFAS; Hodges, 1995). The Family Coordinators were somewhat more positive about the child's functional status than parents and teachers, but indicated that around 30% of the children experienced moderate to serious impairment in age-appropriate role performance (48%), behaviors towards others (29%), and in moods/self-harm (30%). Family Coordinators also reported that many of the caregivers generally were able to provide materially for their children; 70% of the families evidenced no or mild impairment in this area. Providing a nurturing home environment with adequate family and social supports appeared to be more challenging, with 50% of parents experiencing moderate to serious impairment in this area.

Service Delivery, Utilization, and Costs

There were two agencies that contracted to provide FASST services. Both provided the same types of services and both delivered these services in the same settings. For both agencies, 50% of the services were delivered in the home or at school. The breakdown of service types provided includes the following: (a) case management and family support services of the Family Coordinators and the Family Advocates (42%); (b) clinical on-site (i.e., in-home therapy and respite; 39%); (c) clinic-based therapy (18%); and (d) psychiatric services (1%).

Related to understanding the types of services and where they are delivered, is to understand to whom and in what proportions they are provided. To this end, an analysis of patterns of utilization also was undertaken. Program-wide, it was discovered that 66% of case management, clinical, and supportive staff hours were devoted to 26% of children and families. This pattern was remarkably consistent across the six schools. Because this analysis included only services provided directly by the FASST program, it is likely that the analysis underestimates total service utilization across systems to which the child and family may have been referred.

The annual cost of the program per child was $5,300. The Joint Venture FASST funding included the salaries of the Family Coordinators, Family Advocates, the Program Manager, and the Administrative assistant. It also included funds to access a pool of clinic-based therapists, home-based therapists, and respite workers on an "as needed basis" consistent with the families' support plans. The annual cost of services per child is overestimated, since the program is aimed at serving the entire family (i.e., family members also may derive benefit, though they are not necessarily ("billable"). If one accounts for the siblings (an estimated 220 people), and caregivers (conservatively estimated at one per household), the cost falls to $1,281 per year.

Outcomes

Changes in functioning at home and in school were assessed using the Parent and Teacher Rating forms (FMHI, 1995a; FMHI, 1995b). Results suggest that parents felt that their child's behavior had improved at least slightly since the onset of FASST services. Rated on a six-point scale from no improvement to greatly improved, 69% of parents felt their child had made at least modest gains in their behavior at home, and 64% reported similar gains in the child's ability to get along with other family members. Fifty-six percent of parents reported modest to great gains in the child's interactions with peers, and 62% reported at least modest gains in their child's self-esteem. Teachers also noted improvements in child's behavior at school, academic performance, self-esteem, and interactions with peers (see Figure 2).

Changes in attendance, suspensions, grades, and out of home placements were additional measures used to assess the impact of the FASST services. Examination of changes in attendance for 14 subjects (N = 14) between the year prior to enrollment in FASST and the first year of enrollment show a decrease from an average of 18.1 days absent to 14.9 days, which is a positive trend. Suspension data were more difficult to interpret, because differences may be a function of children getting older as well as impact of the program. In the year prior to enrollment there were no documented incidents of in-school or out-of-school suspension. The following year, when children were first enrolled, four children were given in-school suspensions, and 18 children were suspended out-of-school for an average 2.8 days for each event. Grade data, while difficult to standardize, show promise as well. Between the year prior to enrollment in FASST and the year first enrolled, 46% of the children improved in at least one math or reading area. Improvements were more marked in the year first enrolled and the following year, in which 91% (N = 21) improved in at least one math or reading area.

Importantly, children enrolled in FASST were maintained in their homes. After the end of the 1995-6 school year, most children (92%) still lived at home with their natural or extended families. Though 13% of the children had been placed out of home in either foster care or other residential placement, some had returned to their homes by the end of the reporting period. Finally, parents (N = 48) were asked to evaluate: (a) the extent to which their family's strengths were considered in the planning process; (b) whether they had adequate information to make decisions about working with the FASST team; (c) the degree of participation in developing and implementing the Family Support Plan; and (d) whether their opinions were valued, respected, and incorporated in the plans. Figure 3 shows the high level of satisfaction in these particular areas.

There are obvious shortcomings to measuring the outcomes (e.g., primarily relatively small numbers and lack of standardized measures of functioning and achievement). These issues have been addressed through implementing standardized measures of achievement, symptoms, and problem behaviors, as well as home, school, and community functioning and will allow for more precise reporting in the future. Nevertheless, the preliminary attempts to document outcomes show promising trends.

Discussion

In the process of developing the evaluation plan, collecting the data, and interpretation, there were several issues highlighted that affect continued program improvement. These issues can be summarized as caseload issues and data as well as evaluation issues. The "heavy users" analysis in which it was discovered that one-quarter of children and families accounted for two-thirds of staff time led to two issues which are now a topic of program planning. The first of these is determining the optimal caseload mix. This discussion has centered around balancing, perhaps through a weighting scheme, "heavy" versus "regular" users of services, so that all children and families receive an appropriate degree of service intensity and staff availability. The second issue reflects nationwide debate about child versus family-centered services. Upon examining the costs per child and per family member, the issue of "who is the client" was again raised (i.e., the unit of service question). While philosophically the program is intended to meet the family's needs, funding streams still operate on an "identified child" model and staff's efforts are then underestimated. Another caseload issue was that of continuity of care and the wraparound tenet, unconditional care. In the course of collecting data, the high mobility of the target population was documented. Children and families who lived in the catchment area of the six schools at the start of the program had moved to 27 schools within 18 months. While the program is committed to staying with families, the dispersal of families raises logistical and productivity issues for staff who must spend a great of time traveling.

Data and evaluation issues also were raised. Specifically, it was important to the program and evaluation staff that (a) data elements be useful at the individual and program level, (b) they be reasonably easy to get access to, and (c) they be uniformly collected across the two agencies that provide services. The first criteria, broad utility of measures led to the selection of the CBCL, TRF, and CAFAS. For clinicians, these measures produce a profile which can provide feedback and inform the family support planning process. Program-wide, these measures provide a good description of who the children are, and this information can be compared to similar programs in the county. For the evaluation staff, these instruments are well documented psychometrically. Access to the data elements was not consistent and led to both the reformulation of intake paperwork and an on-going discussion of how to integrate and streamline agency and school data requirements, data required by the funders, and data for use in the evaluation. Finally, in compiling service use data, it was discovered that although the two agencies had the same accounting software, billing and accounting practices differed between them, and hence, there were similar but not directly comparable figures available for the proportions of the various services provided.

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Individualized Service Strategies for Children with Emotional/Behavioral Disturbances in Foster Care: Summary of Practice, Findings, & Systemic Recommendations

Authors

Introduction Method Results Discussion References

Introduction

Many children with emotional/behavioral disturbances are adjudicated dependent due to abuse and neglect and languish in the foster care system for years, frequently transferred from one residential placement to another, with little or no progress toward permanency or improved emotional/behavioral adjustment. To explore a possible solution to this situation, the Fostering Individualized Assistance Program (FIAP) was developed to provide individualized wraparound supports and services to foster children with emotional/behavioral disturbances and to their families (i.e., foster, biological, and/or adoptive). Outcome findings from a controlled study suggest that the FIAP intervention was somewhat more effective than standard foster care services in reducing delinquency and externalizing behaviors in boys and in significantly increasing the likelihood of permanency living arrangements for older youth.

Method

The children who were included in this study were in foster homes or group shelter care at the start of the project and had, or were at risk of having, emotional/behavioral disturbances. These children, ages 7 - 15 as they entered the study, had been out of their homes for an average of 2.6 years and were changing placements at an average rate of four times per year. These children represented the most challenging 10% of the foster care population, having been provided few, if any, mental health and related services within the dependency system.

The FIAP goals for its children and families were to stabilize child placement, improve child behavioral and emotional adjustment, and achieve appropriate permanency placements. These goals were facilitated through four clinical components: (a) child and family assessment that addressed individualized strengths and needs; (b) life-domain service planning to support and enhance permanency plans; (c) clinical case management of individualized, wraparound supports and services; and (d) follow-along supports to maintain permanency. At the heart of the FIAP intervention were family specialists who served as family-centered, clinical case managers and home-based counselors, collaborating with parents and other family members, foster caseworkers, other providers (e.g., teachers, therapists, scout leaders), and foster parents. The family specialists followed and served their children across all settings, wrapping services around them, as needed. Our recommendations for individualized, family-focused practices have been published; however, it is important for the reader to understand that these recommended practices evolved over the course of this study (McDonald, Boyd, Clark, & Stewart, 1995).

The FIAP intervention was evaluated in a controlled, random-assignment study that compared a sample of at-risk children who received this individualized, wraparound process (FIAP group, n = 54) with a comparable sample of children who experienced practices that were standard in the Florida foster care system (SP group, n = 77).

Results

The major outcome results suggest that: (a) FIAP children were significantly less likely to change placements than were those in the SP group during the intervention period; (b) both groups showed significant improvement in their emotional/behavioral adjustment over time; (c) FIAP boys were more likely to show significantly lower rates of delinquency and better externalizing adjustment than their SP counterparts; and (d) the older FIAP youth were significantly more likely than SP youth to be in permanency settings with their parents, relatives, adoptive parents, or living on their own. The only statistically significant differences between the groups regarding school differences between the groups regarding school performance were that extreme numbers of days absent were lower for the FIAP youth than for the SP youth, and extreme numbers of days of suspensions were lower for the FIAP group than for the SP group. Examinations of other community adjustment indicators, for subsets of youth who had any history of runaways or incarceration, suggest that the older FIAP youth spent, on average, fewer days per year on runaway or incarceration status during the post period than did the older SP youth (Clark, Lee, Prange, & McDonald, 1996; Clark et al., 1994; Clark et al., in press).

Discussion

Implications for Children's Systems of Care

Through this grant-funded research effort, FIAP has developed and refined an intervention strategy for improving the externalizing/delinquency adjustment of boys and the permanency placements of older youth with emotional and behavioral challenges who have been out of their homes for extended periods. These differential results were achieved even though a new governor and class action law suit provided new resources for the standard-practice foster care and adoption system during this study. It appears that the FIAP intervention strategy might be strengthened further by ensuring greater consistency in the individualized wraparound approach through more systematic use of family therapy and field supervision methods.

FIAP personnel are currently disseminating programmatic information, and providing staff training and technical assistance to improve practices in communities in Florida and in other states. The following recommendations may prove helpful in the reform of practices and policies regarding child-serving agencies for improving the humanness and effectiveness of systems serving children at risk and their families.

Recommendations

Foster care and mental health systems should maximize the likelihood of children remaining in their homes of origin, assuming their safety can be ensured, through the use of family preservation and family systems therapy (Henggeler et al., 1994). For those children who are at risk of having, or do have, emotional/behavioral disturbances and face extended stays within the dependency system (Boyd, Struchen, & Panacek-Howell, 1989; 1990), the FIAP Research Demonstration principals have formulated the following recommendations.

1. Implement an individualized wraparound intervention process that would be external to, but collaborative with, the foster care and mental health systems, to ensure that children with severe emotional disturbances who have been abused achieve appropriate permanency placements (McDonald et al., 1995).

- Establish a wraparound team for each child composed of key players in his/her life (e.g., biological parent, foster parent, teacher, foster counselor, therapist, aunt, and family specialist) to develop and modify service plans, monitor service provision and outcomes, and track progress toward permanency.
- Use family specialists (e.g., clinical case managers), empowered by the wraparound team, to provide child- and family-focused, wraparound services, with an outcome priority on permanency.
- Complete comprehensive assessments with the children and their families (e.g., natural, foster, relative, adoptive), to determine their strengths, needs, and clinical issues. This assessment information should guide the wraparound team in service delivery and permanency planning.
- Ensure that the family specialists and wraparound teams operate under a value of unconditional commitment, in that they will not deny services to a child, but rather adjust services and supports to meet the changing needs of children and their family circumstances (VanDenBerg & Grealish, 1996).

2. Remove all incentives for not providing effective, individualized, family centered care and treatment.

- Do not allow family specialists who work with this population (i.e., children with, or at great risk of having, severe emotional disturbance) to have more than 10 children on their active case loads, keeping in mind that even those children who have been placed in permanent settings will continue to need follow along services. The active caseload of 10 is contingent upon the family specialists not having to provide all of the in-home and out-of-home therapeutic services. They should be in a position to broker and monitor numerous supports and services (e.g., home-based behavioral support therapist, after school mentor, family systems therapist).
- Do unconditionally commit to the development, implementation, evaluation, and follow along of individualized, family-focused services. Provide family specialists with adequate and flexible funds so they are able to address crucial service areas for both child and family (e.g., arrange sexual abuse therapy to occur immediately for victims; purchase of a refrigerator for a mother may remove the remaining barrier to family reunification). Further empower the family specialists with monitoring, facilitating, trouble-shooting, and on-the-spot decision-making authority regarding the implementation of service plans (to be confirmed, or later modified, by the wraparound team).
- Protect against premature, facile, or unsupported Termination of Parental Rights, by careful,

Termination of Parental Rights, by careful, strength-based team review of all such proposals. Similarly, do not specify a permanency plan without a carefully wrought, outcome-oriented service plan attached.

- Do include biological families, as well as foster families, in all planning and decision making. Provide the wraparound team with authority to determine the service and permanency plans that will be submitted to the foster care supervisor and presented to the court.
- Provide family specialists, who have professional training and experience in the provision of culturally sensitive individualized services, with weekly clinical supervision of their case loads and with field supervision on a bi-monthly basis. Identify additional professional expertise (e.g., family systems therapy, behavioral support intervention, sexual abuse therapy) to tap, as needed, for staff training and consultation and/or for direct family services.

3. Link permanent parents with naturally occurring supports in those areas of need which are crucial to successful permanency maintenance of each child in his/her eventual home.

4. Work specifically toward the long-term goal of having each permanency family be its own case manager, averting situations that could cause recidivism or the need for additional services in order to retain the child in his/her permanent home. Be certain to contact each permanent family at planned intervals, to provide support where needed, until self-reliance is reasonably predictable.

5. While stringently monitoring each child's progress towards permanency placement, allow the wraparound team to exceed the legislatively mandated time constraints, as needed (e.g., maximum of 18 months in foster care).

6. Do not allow any more movements of a child from foster home to foster home, and school to school, than absolutely necessary.

7. Use level of severity, age, sex, and number of children as essential determinants of where each child is placed, avoiding inappropriate, dangerous, or combustible mixes (e.g., do not place young, naive, children with older, street-wise youth).

8. Advocate with school staff to ensure that each child is receiving all appropriate services in the least restrictive environment possible. Assist in linking parent and teacher (guidance counselor) to improve the possibility of a coordinated set of services.

9. Advocate for the foster care system to develop and/or expand its use of treatment foster care homes (Chamberlain

& Reid, 1991; Meadowcroft & Trout, 1990; Mikkelsen, Bereika, & McKenzie, 1993).

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Chapter 5

Family Perspectives

Families First in Essex County: A Family Designed and Implemented System of Care

Authors

Introduction Method Results Discussion

Introduction

The goal of this project has been to develop a system of services for families with children with emotional disturbance that is designed and primarily implemented by consumers. From 1993 to 1996, the project was primarily funded by a Department of Health and Human Services Center for Mental Health Services research grant received by the New York State Office of Mental Health. The researchers will be presenting the research results at a future date. This summary presents a more subjective view by the founder and director of the program.

In the past ten years, the consumer movement has changed the face of service delivery, emphasizing the need for voice, ownership, and options for people receiving services, and an end to what our program refers to as "blame and shame." Value has been placed on families and professionals working in a partnership with the family in charge. Despite these values, even the best of systems have been primarily designed by professionals. The following are questions posed by this endeavor:

- What would a program look like that was developed in response to what families said they wanted and needed?
- Is it possible to develop a responsive system in an extremely rural area?

Method

In 1991 several small grants were received to fund a planning year. In-depth, in-home interviews were held with 24 families who had children with serious emotional disturbance and tape recorded for subsequent analysis. The author asked each family the following questions:

- What was most helpful to you?
- What was not helpful to you?
- If you had a magic wand, what services would you wish for?

After the completion of the interviews, a Parent Planning Committee was formed, chaired by the project director. The committee's assignment was to make recommendations for a program based on the interview material. The committee met for eight two-hour sessions, which were videotaped. During the course of this planning year, an Essex County Child and Family Task Force was formed, which included service providers, community people, and consumers. The task force prioritized service system needs and were trained in Child and Adolescent Service System Program (CASSP) principles, with emphasis on family centered services. At each meeting, they heard a speaker who was a consumer tell the story about their experience as a service recipient.

Results

There was almost complete unanimity as to what families reported they needed and wanted. The following needs were expressed by the families interviewed: respite; information and referral; an advocate; community friend/mentor for their child; support for caregivers, siblings, and the identified child; crisis services; concrete assistance; and family center. When professionals design services for families, the services that were prioritized by families are usually developed years after other more traditional services, if at all.

The following is a sample of the 32 recommendations made by the Parent Planning Committee and implemented by Families First in Essex County: (a) Preference should be given to parents of children with special needs in hiring; (b) participants should be included in all trainings, as both attendees and trainers; (c) no interagency meetings should be held about families unless they are present (i.e., "Nothing About Me Without Me"); (d) there should not be any criteria for receiving services other than a family's assertion that their child has emotional/behavioral problems and they would like help; and (e) there should not be any waiting list (i.e., the program should be immediately responsive by providing support services).

More intensive services such as case management are not available to all referrals to Families First, but everyone who calls for assistance can utilize a variety of services. Families calls for assistance can utilize a variety of services. Families may borrow books or videotapes from the Resource Library. They may call the 800 number for support from a parent/professional, or they drop in to the Center for support. Families are provided social events to attend. They can receive the family written newsletter and notices of events. Families may request an initial home visit for planning, or even ask to be matched with another participant for support. Also, they can receive food from the Families First food shelf and concrete help through the flexible dollar fund. Families have access to both respite for child care and the respitality program for an overnight stay in a hotel. Finally, they may have an opportunity to assist another family and/or contribute in other ways to the organization.

The Parent Planning Committee felt strongly that the language that professionals use can connote either respect or blame and shame. They recommended that the following terms be used: (a) "Multi-stressed" rather than "dysfunctional;" (b) "participant" rather than "client;" (c) "family" rather than "case;" (d) "family advocate" rather than "case manager;" and (e) "cautious" rather than "resistant."

The following summarizes the salient learnings from this demonstration project:

- If services meet people's needs, recognize their strengths, and are offered in a warm, hospitable and respectful environment, families will utilize the service. Even those who are usually the most difficult to engage (e.g., low socioeconomic families and mothers who are depressed), will participate.
- Traditional service providers are highly invested in maintaining the status quo and are likely to be very cautious about accepting a new paradigm of family centered service. Although significant changes were made in Essex County, such as having consumer representatives on interagency committees, it took three years before most other providers became comfortable with family centered values and procedures. Many continue to be very cautious.
- Hiring consumers is essential to a family centered service, but it presents many challenges. When staff both deliver and receive service, it requires great flexibility and sensitivity.
- Creating truly individualized, flexible services that incorporate the natural support system requires comfort with ambiguity and complexity, which can be an administrative and bookkeeping challenge.
- There is a tendency to revert to old paradigms. In order to assure that a program remains "family friendly," providers need to always be vigilant against slippage.

Discussion

Families First in Essex County opened its doors in

November, 1992. In 39 months, it has served 250 families, and the county has had fewer hospitalizations and out of home placements. An evaluation survey of consumers yielded a very high degree of satisfaction. Family members have said "Families First is my family," and "I have been lifted out of my depression since I joined the family of Families First." It has been clear that the agency has established a sense of community. The majority of participants assist other families, work in the office, help with social events or serve on the Board or on Advisory Committees.

The project has demonstrated that it is possible to develop a system of services that is designed and implemented by families, and that the resulting program will have services that actually please and delight recipients. It has also demonstrated that a system of family centered support services can function in a very rural area despite the challenges arising from lack of transportation, isolation, and a pool of trained professional people.

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An Examination of the Support Families Receive and Parent Perceptions of How Helpful These Supports are in Meeting the Needs of Their Children and Families

Authors

Introduction Method Results Discussion

Introduction

Families with children who have emotional or behavioral disorders face complex and multiple challenges. Progress has been made to develop child-centered and family-focused systems of support to help families cope with stressful circumstances and access services from the categorical systems. However, parent input is rarely sought when planning, implementing, and evaluating these efforts.

This study examined the nature and extent of support families received from their informal social networks and from paid professionals, and how helpful these types of assistance were in meeting child and family needs. Results indicated that more support was provided by formal organizations and paid professionals than by informal organizations and unpaid individuals. Family members, however, provided the most help/support in coping with daily challenges. In addition, the greater the number of functions of service coordination received, the more successful parents were in accessing formal support and the more satisfied they were with their family's quality of life. Results indicated that receipt of service coordination may contribute to positive outcomes for families with children who have emotional or behavioral disorders. Findings imply that professionals should rely more on parent input to ensure that community support systems effectively address child and family needs.

Method

Mail survey research methods were used to explore the nature and extent of support families received. The following areas were examined: (a) characteristics of children with emotional or behavioral disorders and their families, (b) types of informal and formal support families received, (c) relationships between child and family characteristics and support received, (d) helpfulness of support received, (e) functions of service coordination received, (f) the relationship between receipt of functions of service coordination and parent success in getting help, and (g) the relationship between receipt of functions of service coordination and child well-being and family quality of life.

Participants

Participants were parents residing in Oregon who had a child with an emotional or behavioral disorder. A sample of 250 parents was randomly selected from the Oregon Family Support Network (OFSN) database of 1000. The OFSN is a statewide, parent-run, information and family advocacy organization to support both the children and youth with emotional, behavioral, and mental disabilities and their families.

Survey packets were mailed to all selected parents. A total of 120 surveys were returned. Of these, 100 met the requirements for inclusion in the sample to be used for data analysis. The 40% return rate of useable surveys was sufficient to answer the research questions.

Instrument

A self-administered questionnaire was used for data collection. The instrument was pilot tested by meeting with three parent-run support groups. A total of 18 parents, representing (a) rural and urban settings, (b) a range of ages, incomes, and educational attainment, and (c) with children of different ages and disability labels, attended three separate meetings. As a result of the pilot test, minor changes were made in both the terminology and instructions for completing the survey.

Reliability

The survey was divided into five parts. A test-retest reliability procedure was conducted by mailing each of the four parts of the questionnaire that included quantifiable responses to four subgroups of the 100 respondents approximately one month after receipt of the original questionnaire. Absolute agreement was calculated for Part I (family characteristics) and Part II (child characteristics). For Part I the agreement ratio was 89%, and for Part II the agreement ratio was 82%. For Part III (support families received), the percent of agreement was 77% and for Part IV (family service coordination and family outcomes), the percent of agreement was 87%. Pearson Correlation percent of agreement was 87%. Pearson Correlation Coefficients were calculated for items with interval data in Part III and Part IV. The highest reliability coefficient was .90 for responses related to family service coordination. The lowest was .73 for the items related to helpfulness of support received. Inter-rater reliability for Part V, the one open-ended question, was calculated for 10 of the 65 parents who responded. The average agreement between raters was 85%.

Analysis

Descriptive statistics (frequencies, percentages, means, and standard deviations) and statistical analyses were conducted using the Statistical Program for the Social Sciences (SPSS). When testing statistical significance, a conservative alpha level of $p < .01$ was used to protect against experiment wise error for t-test results, chi-square test of association, Pearson Correlation Coefficients, and Friedman Two-Way Analysis of Variance by Ranks.

Results

Respondents represented families residing in 22 of Oregon's 36 counties, characterizing the general population of Oregon. The children and youth with emotional or behavioral disorders reflected the racial mix of the national population, with a slightly lower percentage (87%) reported as Caucasian than in the Oregon population. A wide range of child and youth disability categories were represented. The range of disability labels per child was 1 to 9, and a mean of 2.6 per child. Of the 100 children and youth represented in this study, 82 (82%) were participating in-school programs, with the largest number (72%) attending in-school programs that were not associated with day or residential treatment.

Parents were asked to report the extent to which their families received the functions of service coordination during the past year. These functions were: (a) assess the needs and strengths of the child and family; (b) develop the family service plan; (c) link the child and family with services appropriate to child and family needs; (d) monitor the delivery of services and child and family progress toward goals; (e) advocate for the child and family; (f) provide information to parents regarding where to find resources; and (g) teach self-advocacy.

Of the 100 respondents, 29 (29%) reported receiving none of the 7 functions of service coordination. The assessment function was received most frequently (n = 59). The least frequently received function was self-advocacy (n = 14). The pattern that emerged was that as the number of functions received increased, the number of families receiving those functions decreased. School personnel provided service coordination more frequently than any other discipline (n = 29) and schools combined with education service districts accounted for 44% of the service education service districts accounted for 44% of the service providers identified as delivering functions of service coordination.

Families with children ages 11 to 18 received more functions of service coordination than those ages 3 - 10 and 19 - 28; the group of 11 families with young adults ages 19 to 28 with emotional or behavioral disorders received less service coordination than the other age groups.

To examine the relationship between the extent of service coordination families received and overall parent satisfaction with family quality of life, satisfaction was measured on a scale of 1 to 4, with 1 being "not at all satisfied" and 4 being "very satisfied." The mean satisfaction rating for 91 parents was 2.19 (SD = .9). The Pearson Correlation Coefficient of $r = .2675$ was statistically significant at the $p < .01$ level of significance, indicating a positive relationship between parent satisfaction with family quality of life and number of functions of service coordination received. Statistical analysis of the relationship between parent success in being able to get the support their child and family needed and the receipt of functions of service revealed a significant positive relationship between these two variables ($r = .3387$; $p < .01$). In addition, a correlation of $r = .6180$ ($p < .001$) indicated a strong positive relationship between parent success in getting help and family quality of life.

The open-ended question asked parents to provide additional information about the support their child and family received. As a result of content analysis, 11 themes emerged. Of these, three were considered the most relevant to the purpose of the study: (a) parent feelings, (b) parent needs, and (c) parent recommendations. Parents' expressions of stress and difficulty in coping were described more frequently than feelings of satisfaction and hopefulness. Parent needs were categorized in 7 primary categories. These were (a) respite care, (b) transition services, (c) services for young adults (independent living: vocational, life skills, recreational), (d) service coordination, (e) financial assistance for health services, (f) child's behavior to be more positive, and (g) support for relinquishing custody. Recommendations made by parents included increased flexibility and coordination of services across the categorical systems.

Discussion

This study explored the nature and extent of the informal and formal support families receive and how helpful these types of assistance were in meeting the needs of both children who have emotional or behavioral disorders and their families. The socioeconomic characteristics of the families reflected the general population of Oregon. Child characteristics were consistent with the literature describing the characteristics and educational placements of children and youth with emotional or behavioral disorders. However, findings may not be generalizable to the population of children, youth, and families since the sample was purposeful.

Families received support from both formal and informal sources. However, parents relied mostly on family members (informal support) when they needed someone to talk to about the daily challenges they faced. In addition, even though support received was generally perceived as helpful, parent anecdotal comments suggested that the current service system continues to be fragmented and difficult to access.

Findings from this study support continued efforts to provide service coordination within a child-centered and family-focused system of support. Statistically significant relationships were found between parent success in getting needed help and the number of functions of service coordination received. These findings suggest that family service coordination may be an effective means to ensure that families receive timely and appropriate assistance.

Results from this study support future research that examines community service delivery programs that systematically incorporate informal social networks into community-based service delivery in order to increase the amount and availability of support, and also more closely match child and family needs with the resources most appropriate to meet those needs. This concept appears more promising as local communities look for innovative ways to transform the categorical systems at a time of dwindling resources and increased demand for government accountability.

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Evaluating Mental Health Services for Children: The Parent's Perspective

Authors

Introduction Method Results Discussion References

Introduction

Mental health services for children have been described as inaccessible, inappropriate (Saxe, Cross & Silverman, 1988), fragmented, duplicated, too restrictive, not community based, being driven by the needs of the providers or payers rather than by the needs of children and their families, and for failing to include parents as part of the treatment team (Knitzer, 1982; Young, 1990). With a history of inadequate services, the need exists to assure that appropriate treatment is available for children with mental health problems and their families.

The purpose of this study was to gain information about parents' perceptions of and satisfaction with mental health services for their children. Parents' satisfaction is an important outcome measure that serves as an objective of service delivery and a factor in improving future services. Parent's level of satisfaction was defined as the degree that the parent was pleased with parent-staff interactions.

Method

Research Questions and Data Analysis

This was a cross-sectional, descriptive study that explored relationships among variables at one point in time.

The following research questions were developed:

1. How do parents describe their situation of having a child with a mental health problem?

2. What services do parents desire?

3. How do parents expect to be treated by staff?

4. What are parents' perceptions of staff?

5. What was parents' level of satisfaction with staff?

6. What variables are associated with parents' satisfaction?

7. What variables are associated with child's current living situation?

Descriptive statistics, frequencies, and themes were utilized for the first five questions. T-tests and correlations were used to analyze the association of variables with the dependent variable, parents' satisfaction. T-tests were also used to analyze the association of variables with the dependent variable, child's current living situation.

Subjects

The participants in this study were parents of students with mental health problems who were part of an Alternative Residential Services (ARS) program with state special education fiscal support. Students receiving ARS who were 9 years of age or older were also invited to participate in the study along with their parents. A total of 160 mailings were sent to family units. At least one response came from 47 family units (30% response rate), including 46 mothers, 24 fathers, and 25 students.

Students

Students were primarily boys (84.8%) and were between the ages of 7 and 20 years (M = 14.4 years). Parents reported that students had mental health or behavioral problems for 3 to 20 years (M = 11.2 years). Both mothers and fathers similarly rated the seriousness of the students' mental health or behavior problems as 3.9 on a five-point numeric scale with 5 being "a serious problem" and 1 being "no problem."

Children's placements for services were 42.6% at home, 36.2% in in-state residential settings, and 12.8% in out-of-state settings. Another 8.5% were in other settings such as a nursing home and a supervised, independent living such as a nursing home and a supervised, independent living situation. The average per child expenditure of ARS funds was $53,019.26 for the 1994-95 academic year, with a range of $0 to $171,232 annually.

Instrumentation

Parents described their situation with: (a) the Parent's Stressors Scale, (b) the Cause of my Child's Problem Scale (CMCP), and (c) the Burden Assessment Scale (BAS).

The Parent's Stressors Scale. Parents identified and prioritized the stressors they experienced as parents of children with mental health problems.

The Cause of My Child's Problem Scale (CMCP). The 18-item CMCP, a revision of McCauley's (1992) Causal Dimension Scale II, measured six causal dimensions including: (a) locus of causality within or external to the parent; (b) stability; (c) personal control; (d) external control; (e) locus of causality within or external to the child; and (f) pervasiveness. The coefficient alpha for the current study was .65 for mothers and .64 for fathers.

The Burden Assessment Scale (BAS). The 19 item BAS, a revision of Rinehard's BAS (1994), measured parents' perceived burden, including objective and subjective burden. The coefficient alpha in the current study was .93 for mothers and .91 for fathers.

Three other factors related to parent satisfaction were measured, including:

- The Parent Satisfaction Scale (PSS). The 7-item PSS measured parents' level of satisfaction with their interactions with staff (Gerkensmeyer, 1996). Coefficient alpha in the current study was .91 for mothers, .87 for fathers, and .87 for the child version.
- The Parent-Staff Interaction Scale (P-SIS). The 13-item P-SIS measured parents' perceptions of how they were treated by staff. (Gerkensmeyer, 1996). Coefficient alpha in the current study was .94 for mothers, .87 for fathers, and .87 for the child version.
- The Expectation of Staff Interactions Scale (ESI). The 5-item ESI, developed by the author, measured expectations the parent or child had about staff. Coefficient alpha in the current study was .89 for mothers, .72 for fathers, and .89 for the child version.

Results

How Parents Described Their Situation

Parents' Stressors. The weighted, prioritized stressors identified by the parents included: (a) child focused stressors obtaining 406 points (32%); (b) parental role stressors obtaining 356 points (29%); (c) service system stressors obtaining 342 points (27%); and (d) family focused stressors obtaining 342 points (27%); and (d) family focused stressors obtaining 162 points (13%).

The Cause of My Child's Problem (CMCP). Parents did not believe they had personal responsibility for causing their child's mental health problem. The CMCP scale least endorsed by parents on the CMCP was the parents' locus of causality subscale (i.e., within you as a parent; M = 3.8 on a nine-point scale).

Overall, parents tended to explain their children's mental health problems as pervasive, likely to last forever, and not caused by themselves. The most highly endorsed CMCP items by mothers were will affect all parts of your life and is inside your child (M = 7.1), followed by "will last forever" (M = 7.0). For fathers, the most highly endorsed item was will last forever (M = 7.2), followed by is inside your child (M = 6.7).

Burden Assessment. The parents' most highly endorsed BAS item was worried about what the future holds for your child (M = 3.7 on a 4 point scale). The least endorsed burden for both mothers and fathers was resented your child because s/he made too many demands on you (M = 2.0 and 1.9, respectively).

Parents' Desired Services

Several parents (48%) indicated that they wanted exactly what services their children were receiving. Parents also endorsed that they wanted respite services (34%), school based services (27%), in state residential services (27%), home based services (18%), out patient counseling (15%), in-state hospitalization (8%), and partial hospitalization (5%). None of the parents endorsed wanting out of state services; however, 50% (6 out of 12) of those receiving out-of-state services endorsed wanting exactly what they were receiving.

Expectations of Staff Interactions

Mothers and fathers most strongly agreed that they expected to be treated well by staff. Parents least agreed that staff treated them better than they expected.

Perceptions of Staff Interactions

In general, parents had highly positive perceptions of, and satisfaction with, their interactions with staff. The most negative perceptions were within a neutral range. Positively skewed data have been a consistent, long standing problem with consumer satisfaction and perception data (Lebow, 1982), therefore, in identifying areas to improve, the least positive responses need to be targeted, even if, as in this study, they fall in a neutral range. Mothers and fathers did not describe the staff as rude to them (M = 2.2 and 2.0, respectively on a five-point scale with 1 = strongly agreeing and 5 = strongly disagreeing with positive perceptions of and 5 = strongly disagreeing with positive perceptions of staff interactions). The most negatively endorsed perceptions for mothers were that: (a) staff were (not) helpful in identifying community resources (M = 3.0), (b) staff had limited skills to help their children (M = 3.0), and (c) staff (did not) ask their opinions about what help their families needed (M = 2.9). The most negatively endorsed perceptions for fathers were that: (a) staff were (not) helpful in identifying community resources (M = 2.9), (b) staff (did not) fit services to meet the needs of their children (M = 2.9), and (c) staff were (not) very supportive when they were in distress (M = 2.8).

Level of Satisfaction

Mothers and fathers were least satisfied with how staff helped them find services their children needed (M = 3.0). They were most satisfied with how the staff treated them with respect (M = 2.3) with the lower mean representing greater satisfaction.

The Influence of Child's Current Living Situation

The child's living at home was associated with significantly higher levels of parents' total burden, subjective burden, and fathers' objective burden. Further, of the children living out of their home, those living out-of-state had significantly lower levels of parents' subjective burden, total burden, and mother's objective burden than those with in-state, residential placement (see Table 1).

Parents' Satisfaction

The more satisfied mothers were, the more (a) positive their expectations, (b) helpful they found ARS services, (c) positively staff interactions were perceived, (d) likely parents were to recommend or return to the staff for services, and (e) satisfied fathers and children were with staff interactions (see Table 2 for correlations).

The more satisfied fathers were, the more (a) positive mothers' expectations, (b) likely fathers would recommend or return to staff for services, (c) positively parents perceived staff interactions, and (d) satisfied mothers were. Further, the more satisfied the fathers, the less pervasive mothers viewed the child's problem, the younger the child was, and the shorter length of time the child had a problem. Fathers were also more satisfied when the child was placed out-of-state and least satisfied when they lived at home.

Discussion

With a 30% response rate and small sample size, the findings must be interpreted cautiously. Nevertheless, the findings provide some information concerning the parent's perceptions of their experiences with mental health services.

Parents' satisfaction scores suggest that parents were generally satisfied with the interpersonal interactions of staff. Provision of effective case management is indicated by parents' decreased satisfaction with the staff's ability to help them find needed services for their children and the parents' concern for their children's future.

With parents' level of burden significantly related to their child's current living situation, provision of effective support and resources is indicated in order to assure families' success and well-being when children with mental health problems are living at home. Parents' most highly endorsed desired service, respite service, was consistent with their need for support. Furthermore, services need to address fathers' needs, as fathers had significant increases in all of their burden scales when children with mental health problems lived at home.

With a significant relationship found between parents' reported intent to return or refer to staff and their level of satisfaction, parent satisfaction may be more than an objective of care or a factor in improving services. Parents' level of satisfaction with staff interactions may also be associated with subsequent behavior (e.g., continued engagement with the service delivery system). If so, parents' satisfaction may be associated with other functional outcomes for children with mental health problems. Further research is indicated to substantiate this relationship.

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Reliability of Parent Reports of Service Use in a Family-Focused System of Care

Authors

Introduction Method Results Discussion References

Introduction

Various efforts to restructure the mental health service system for children and adolescents have identified the value of a full continuum of services, coordinated by a case manager, in which families are encouraged to actively participate (Stroul & Friedman, 1986). Adequate assessments of the effectiveness of such "systems of care" require accurate information on service utilization. Very often, utilization data are obtained from a parent of the child client. This research examines whether parent reports of their child's service use are more reliable in a family-focused delivery system than in more typical service environments that do not explicitly embrace "system of care" principles.

Methods

Sample

Data were obtained through the Fort Bragg Evaluation Project (FBEP), a longitudinal assessment of a managed care model for delivering mental health services to children and adolescents (hereafter, the "Demonstration"). The present research is based on about 600 youth who remained in the study six months after intake to the Evaluation, for whom collateral service-related data were collected.1 About 60% of this sample received services through the family-focused Demonstration, and 40% through two traditional systems of care (hereafter, the "Comparison groups"). On average, the sample was about eleven years old, about 60% male. Seventy percent were white, 20% were African American; and 10% were of other or mixed races. About 80% lived in a two-parent household, with an annual income between twenty and forty thousand dollars. Over 90% of the youth had significant functional impairment (CAFAS; Hodges, 1990); over 97% obtained at least one clinical diagnosis based on parental responses to the Child Assessment Schedule (P-CAS; Hodges, Kline, Stern, Cytryn, & McKnew, 1982).2

Data Sources/Measures

Utilization data were obtained from the youth's primary caretaker (i.e., usually the biological mother) and institutional records (i.e., the management information system (MIS) at the Demonstration);3 and the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) database for the Comparison groups. The following service categories are examined: a) hospitalization (HOSP), b) residential treatment (RTC), c) outpatient therapy (OUT), and d) medical evaluations (MEDEVAL).4 For each category, two measures of utilization are analyzed: service use (i.e., "yes" or "no") and service dose (i.e., the number of service units received). Data are based on reports of use in the first six months after intake. Because parents may miss the distinction between hospitalization and residential treatment, or between outpatient care and medical evaluations, two general categories of use are created. "Restrictive" care includes hospitalization or RTC; "nonrestrictive" care includes outpatient care or medical evaluations.5

Analyses

Identical analyses of reliability were performed on the Demonstration and Comparison groups. First, the percentage of children who used each service type is reported based on each data source. Because parent and institutional reports can reveal identical rates of use without any association between the reports, proportional agreements between the two sources are also provided. Kappa coefficients, which indicate whether the agreement is better than what would be expected by chance (Cohen, better than what would be expected by chance (Cohen, 1960) are shown.6 Agreement can arise because parents concur with institutional reports of use (i.e., "sensitivity") or nonuse (i.e., "specificity") (Kraemer, 1992). Therefore, data are also shown to indicate the nature of agreement between parent and institutional reports. Finally, correlations between collateral reports of service dose are shown.

Results

Table 1 shows that parents in the Demonstration and Comparison groups tend to report roughly equivalent rates of service use as found in their respective institutional records. Exceptions include parental overreporting of medical evaluations in the Demonstration and of RTC use among the Comparison groups.

Table 2 shows high percentages of agreement between parent and institutional reports for all service types, in both service systems. The proportional agreement on medical evaluations, though good, is the lowest observed. Most notably, Demonstration families indicate much better accuracy than the Comparison group with regard to nonrestrictive care, specifically for outpatient care. The kappas indicate that when chance agreement is eliminated, parents in both systems continue to report reliable use of restrictive care. Low kappas for nonrestrictive services are largely due to the relatively inaccurate reports of medical evaluations and the large number of youth who received outpatient care.7 In short, participants in the family-focused system of care provide good reports overall, better than their counterparts in traditional systems with regard to nonrestrictive services, though no better with regard to restrictive care.

Figure 1 shows that reliability depends on whether one considers the sensitivity or specificity of reports.8 Regarding restrictive services, the strong overall agreement at the Demonstration (in Table 2) is largely explained by high specificity (98%). Sensitivity of these reports is relatively low (69%), with parents at the Demonstration tending to underreport.9 The pattern among families in traditional systems is similar; they also show greater specificity (94%) than sensitivity (86%). While their specificity rate is comparable to that of the Demonstration, their sensitivity rate is higher.

The findings with regard to generalized, nonrestrictive care show greater sensitivity than specificity in both types of systems. Outpatient care in particular is overreported. However, this finding must be interpreted in context of the number of clients who received outpatient care. When so many receive the care, only a few cases incorrectly reporting its use would generate a high inaccuracy rate.10 The skewness of the sample's distribution is less severe in the Comparison group, where 11% did not receive outpatient care. Indeed, perhaps the most striking finding about reports of nonrestrictive services is the low specificity rate (17%) in of nonrestrictive services is the low specificity rate (17%) in the traditional systems. Sensitivity of reports of nonrestrictive services is comparable in both service systems. The low reliability of medical evaluation reports in both systems is largely attributable to low sensitivity (i.e., underreporting).

Table 3 shows that parent reports on doses, as with use, are more accurate for restrictive than for nonrestrictive care. In both systems, correlations between parent and institutional records of generalized restrictive care are high and the difference between systems is not significant. When hospitalization is examined specifically, however, the correlation at the Demonstration (r = .88) is significantly higher than in the Comparison group (r = .31). On the other hand, correlations at the Demonstration for nonrestrictive care are low, and significantly lower than among the Comparison groups.

Table 4 summarizes the findings. A plus sign indicates the system with the stronger association between parent and institutional reports; a minus sign, the system with the weaker association. Of the seven specific service categories that can be compared, reports for the two service systems differed significantly on six. Of these six, four favored the Demonstration; two, the Comparison group. The general measures indicate that the accuracy of Demonstration families' reports of use and dose of restrictive care is about the same as observed among families in the traditional systems. For nonrestrictive services, Demonstration families tend to be more accurate with regard to use, but less accurate on questions about the number of service units rendered.

Discussion

Efforts to provide more effective mental health services for children have embraced the value of including children's families in the treatment process. This paper explored the possibility that parent reports may be more reliable in a family-focused system than in traditional systems that do not explicitly pursue family-focused interventions. Findings suggest that participants in a family-centered system generate reliable utilization data. However, their reliability does not consistently exceed that observed in traditional environments. With regard to restrictive care, this may be due to the introduction of innovative, intermediate services the Demonstration made available. Families at the Demonstration showed a greater likelihood of underreporting restrictive care than those in the Comparison group, a phenomenon that may relate to the greater number of additional services they received through the Demonstration.11 Reports of the use of nonrestrictive care are good; however, reports of dose are not very reliable, and significantly more unreliable than among the Comparison groups.

The Demonstration represented a new and rather complex

The Demonstration represented a new and rather complex structure with which parents and professionals alike had to familiarize themselves. The lack of consistent superiority in reliability of utilization reports through the Demonstration suggests such organizational challenges may have impeded the system's intended capacity to meaningfully include parents in treatment planning. Other research (Sonnichsen & Heflinger, 1993) has also found that families at the Demonstration were not significantly more involved in restrictive services than parents at the Comparison sites (though they were more involved in nonrestrictive care). Together, these findings suggest that we may need to reorganize or redouble our efforts to include families as active, knowledgeable partners in the therapeutic process. Moreover, it may be that any added value of family-focused service systems for reliable parent reports may obtain only after participants in the system have time to adapt to the new organizational environment.

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Endnotes

1. The follow-up sample used for this research is more limited than in the original Fort Bragg database described elsewhere (Bickman, et al., 1995). First, about 10% of the Demonstration sample has been excluded because they "transitioned" into a different level of care at the time they entered the evaluation. These parents may have unusual difficulty in distinguishing between services received before and after transition, particularly when these services represent treatment for the same episode. Second, about 100 cases at the Demonstration, who indicated their childhood an initial pretreatment visit but did not return for treatment were excluded from analyses. Finally, a small number of parents in the Comparison group indicated that outpatient and medical evaluations were not paid by CHAMPUS. These cases were excluded because the transactions would not be included in the CHAMPUS database. Thus, the research is based on the approximately 600 cases for which service use data could be expected in both the parent and institutional database for the same six-month interval.

2. The child and family profiles of the Demonstration and Comparison groups were similar on factors that may differentially affect parent recall of services, for example&endash;the types or degree of their child's problems and their previous experience in the mental health system. See Bickman, et al., 1995 for more details on the sample and its representation of other youth in treatment.

3. Previous analysis compared the Demonstration's MIS and provider data and found strong agreement between the two sources (Bickman, et al., 1995). Thus, the institutional record is considered the "gold standard" in this research, to which reliability of parent reports is assessed.

4. The Demonstration offered intermediate levels of care (e.g., day treatment) that were unavailable to the Comparison groups. Only the four service types offered through both service systems are included in this research.

5. Multiple reports of use of the same service type within the six month period are counted once. Dosages associated with multiple reports of the same service type are summed. Thus, service use and dose represent service types used and the total dose received, regardless of the number of episodes or providers associated with each service.

6. Kappa estimates of reliability decrease as the proportion of cases across categories departs from equality. In these data, a sizable majority of cases is classified similarly&endash;for example, more than 90% who indicate use or nonuse of some services. In this situation, the likelihood of chance agreement is extremely high and the ability to improve prediction beyond chance (as indicated by kappa) is weak. Further, estimates of reliability also

decrease as the number of response categories decreases. Thus, kappas will be lower for the nominal yes/no dichotomies used here to indicate service use then would be expected for ordinal measures. Given these properties of kappa and of these data, kappas should be interpreted in conjunction with other findings presented.

7. It is difficult to improve upon chance, thus obtain large kappas, when the vast majority of cases fall into the same category which is the case here with outpatient care.

8 Less sensitive reports suggest that parents underreport service use; less specific reports suggest parents overreport use. Cases (indicated by dots for the Demonstration, triangles for the Comparison groups) in the upper right quadrant of Figure 1 suggest relatively high specificity and sensitivity. Symbols that lie below or to the left of this quadrant suggest diminishing specificity and sensitivity, respectively.

9. At the Demonstration, too few cases had reports of RTC use, and a sensitivity measure was not calculable. Because both sensitivity and specificity measures are required for charting, Figure 1 does not include an indicator ("dot") of RTC use for the Demonstration.

10. The proportion of clients who overreport is based on the total number of clients who did not receive that type of care. For the Demonstration, only 2% (N = 5) of families did not receive outpatient care. Thus, just two clients incorrectly reported use yielding a 40% inaccuracy rate.

11. Summerfelt, Foster, & Saunders, (1966) report greater service use among children at the Demonstration than at the Comparison sites. Further, auxiliary analyses were conducted on Demonstration clients to ascertain whether their underreporting of restrictive services was associated with overreporting of other service types. Findings showed that underreporters tended to report a greater number of other services than parents who accurately reported services, particularly, intermediate residential services&endash;those that parents may be most likely to confuse with traditional restrictive settings. And, official data corroborated the parents' reports&endash;underreporters did in fact receive a somewhat greater number of other services than accurate reporters (3.0 vs. 1.5). This suggests that the basis for underreporting may be due to confusion that understandably may result when multiple services are provided. However, confidence in these findings is dampened by the small number of clients at the Demonstration who received intermediate services.

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Congruence Between Parent-Professional Ratings of Level of Functioning: Relationships to Collaboration and Satisfaction

Authors

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Introduction

Parents of children with emotional and behavioral disorders often feel that they are not treated as equal partners in their children's services (Collins & Collins, 1990). Often, they are not consulted by professionals regarding the needs of the children (Evans, Armstrong, Thompson, & Lee, 1994). Parental participation in children's treatment decisions, however, has begun to be a mental health system goal that is embraced by both family members and mental health professionals (DeChillo, Koren, & Schultze, 1994; Evans et al., 1994; Friesen & Korloff, 1990). Indeed, parent-professional collaboration is being recognized as a component of professional service delivery (Friesen & Schultze, 1992; Edelman, Greenland, & Mills, 1992).

There has been a lack of research into the relationship of collaboration to other service goals such as satisfaction and parent-professional agreement about child treatment priorities. The present study sought to (a) replicate and expand upon findings of DeChillo et al. (1994) that suggest a relationship of parent-professional collaboration to parents' satisfaction with their children's mental health services; (b) explore the relationship of parent-professional congruence on ratings of level of functioning (LOF) to degree of collaboration; and (c) examine the relationship of parent-professional congruence on ratings of LOF to parent satisfaction with services.

Method

Participants

Parents (N = 76) of youths receiving mental health services at six rural and urban community mental health centers (CMHCs) in Washington state participated in this study as part of a longitudinal study on regulatory reform. Mental health professionals completed surveys on a total of 41 youths. The sample of youths was 71% male, 8% ethnic minority, and ranged in age from 4 to 18 years old. The most common DSM-IV diagnoses were adjustment disorder (44%), attention deficit disorder (22%), and oppositional defiant disorder (14%). Ninety-three percent of the sample was Medicaid-eligible.

Instruments

Parent Survey

The Client Satisfaction Questionnaire (CSQ-8; Attkinson & Zwick, 1982), an 8-item parent report of service satisfaction, originally developed by Hargreaves and Attkinson in 1978, is rated on a 4-point scale. This widely used scale has demonstrated adequate internal consistency (alpha = .93).

The PSU Family/Professional Collaboration Scale, a 20-item questionnaire, was constructed by DeChillo et al. (1994). This scale asks parents to rate their child's mental health professional's responsiveness toward them on a 4-point scale. There are five factors which are considered in this scale (i.e., supportive understanding, accessing services, sharing information, utilizing feedback, and overall collaboration).

Parent and Professional Survey

The Ecology Rating Scale (ERS) was developed by quality assurance staff at a local CMHC with input from family members of consumers and mental health providers. The 7-item questionnaire, rated on a 5-point scale, measures behavioral/emotional impairments in the following life domains: (a) family, (b) school, (c) emotional, (d) legal, (e) recreational, (f) health, and (g) social. This scale has demonstrated adequate internal consistency (Srebnik, 1996; alpha = .70 for parent raters; alpha = .69 for professional raters).

Results

Examining the relationship of parent-professional collaboration to parental satisfaction with their children's mental health services, a significant correlation was found between the CSQ total score and the total score on the Family/Professional Collaboration Scale ($r = .76$, $p < .001$; see Table 1).

The relationship of parent-professional congruence on

The relationship of parent-professional congruence on ratings of LOF to degree of collaboration was also explored. As a first step, differences between parent and professional ratings of LOF, using the ERS, were calculated using t-test comparisons. Parent and professional ratings were significantly different in the following domains: (a) family, (b) legal, (c) health, and (d) social (see Table 2).

The total ERS discrepancy score was then calculated (i.e., the difference between parent and professional ratings in each life domain of the Ecology Rating Scale). This discrepancy score was not significantly correlated with the total score on the Family/Professional Collaboration Scale, ($r = -.154$, $p <$ ns; see Table 1).

The relationship of parent-professional congruence on ratings of child LOF to parent satisfaction with services was also explored. However, there was no significant correlation found between the total ERS discrepancy score and the CSQ total score ($r = .161$, $p <$ ns; see Table 1).

Discussion

The results of this study reaffirm the findings of DeChillo et al. (1994) that parent satisfaction seems to be related to parent-professional collaboration. Parents and professionals in this study, however, seemed to differ in their perceptions of children's level of functioning in several areas. Professionals perceived family and social domains as areas of greater child impairment; parents perceived legal and health domains as areas of greater child impairment. One explanation for these differences may be professional emphasis&endash;given training in family systems approaches and negative peer group influences&endash;on family and social impairments. Parents, embedded in the family, may also be less likely to perceive the family domain as a child's main problem area. Both of these divergent perspectives on child functioning may be valid: parents and professional should continue to form partnerships where the open exchange of ideas and information is encouraged.

Parent-professional collaboration does not seem to be associated with congruence of parent-professional LOF ratings. One explanation for this finding may be that parents perceive the interpersonal and supportive aspects of the collaborative relationship as more important than a shared view of their child's functioning. This interpretation is supported in part by the relationship found between parent satisfaction with services and perceptions of collaboration.

Satisfaction does not seem to be related to congruence of parent-professional LOF ratings. Again, parent satisfaction may depend on a number of factors (e.g. service availability and treatment outcomes), and divergent perspectives on child LOF may not play a major role in parent evaluation of services. Furthermore, a global satisfaction rating, such as the CSQ, may be less useful than a measure of satisfaction the CSQ, may be less useful than a measure of satisfaction with individual service providers to investigate parent-professional agreement. It could also be that the relationship of satisfaction to congruence in LOF ratings is mediated by the degree to which services are actually provided to meet identified areas of functioning. A next step to further this line of inquiry would be to test the relationships of LOF rating congruence, the extent to which services were provided to meet identified need and service satisfaction.

Overall, this study suggest that global service satisfaction is more related to characteristics of the parent-professional relationship (i.e. collaboration) than the degree of agreement in how they view the severity of the child's difficulties. However, in order to provide specific and appropriate services, the differences in the "lenses" through which parents and professionals view a child's problems should be addressed.

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The Access Vermont Initiative: Evaluating Family Empowerment

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Introduction

Within the field of mental health, there is an increasing sentiment that services for families should be designed to promote empowerment. Empowerment has been conceptualized as both a temporary state of being and an ongoing process involving change within the individual. Although no single definition of empowerment has been proposed that captures both conceptualizations, a growing consensus has come to see it as a process through which individuals gain control of their lives through exerting influence over their interpersonal and social environments. Within the context of human service delivery systems, the process of empowerment is thought to occur when families are provided with opportunities to access the knowledge, skills, and resources that foster control over their lives and improve its quality (Singh et al.1995).

A current model specifically designed to describe empowerment for families who have children with serious emotional disabilities was introduced by Koren, DeChillo, and Friesen (1992). This conceptual framework proposed two dimensions for empowerment&endash;level and expression. The levels of empowerment were further defined as Family, Service System, and Community/Political. The second dimension, expression of empowerment, consists of Attitudes (what the parents feel and believe); Knowledge (what they know and have the ability to do); and Behavior (the actions of parents).

In light of this model, Koren, DeChillo, and Friesen (1992) suggested that empowerment might be a developmental process where parents' focus moves from immediate family concerns, to securing information and services they need to address their child's need, and finally to action to assist other families and address the needs of all children. In order to examine this model, they created the Family Empowerment Scale (FES) which is a measure of empowerment within families with children having serious emotional disabilities. Initially tested with a sample of 440 parents, factor analysis of the FES results supported their empowerment model. To further test this conceptual framework, Singh, Curtis, Ellis, Nicholson, Villani, and Weschler conducted a study and factor analysis resulting in a factor structure similar to the FES (1995).

The FES was selected as a measure of family empowerment for the evaluation of the Access Vermont Project, a multilevel crisis intervention jointly funded by a Community Mental Health Services grant and Vermont's Family Preservation Initiative. The FES, however, was previously tested with populations whose demographics were quite different from those of families served by the Family Preservation Initiative; the current study population was poorer, comprised of more single parents, and fewer parents who participated in support groups. This summary describes assessment of the FES for use with a population more typical of crisis services-oriented family preservation programs, and includes comparison of our evaluation's factor results to the factor structures and conceptual framework derived by Koren, DeChillo, and Friesen (1992).

Method

Subjects

Evaluation participants included the primary caregivers of the first 100 eligible children and adolescents to complete the intake procedures during the evaluation period of the Access Vermont Project. To be eligible for inclusion in the evaluation, the child or adolescent had to be referred for crisis services, and determined to require a treatment team and services from two or more community agencies.

As stated before, the demographics of these families differed from those participating in previous studies utilizing the FES. For example, in the Koren et al. (1992) study, 21% of the families had annual incomes over $50,000 and only 14% earned less that $10,000 a year. Similarly, in Singh et al. (1995), 19% of families had incomes over $50,000, with 17% reporting incomes of $10,000 or less. In contrast, 86% of participants in this study reported annual incomes of less that $25,000; no families reported incomes of over $50, 000. Consequently, these families were more likely to turn to the public service system for help rather than private therapists. Additionally, in both Koren and Singh, many families reported that they were members of support groups or organizations for families with children with serious emotional disabilities. The families in the Access Vermont sample came to the program in crisis, and none reported participating in a support group prior to receiving these services.

The previous studies had a male population of over 70%, whereas males in the current study represent 49% of the sample. Another significant difference is in the percentage of children living in single parent homes. In Koren, et al. (1992), only 28% of the children lived in single parent

(1992), only 28% of the children lived in single parent families; in our study, the percentage was 43%. The strongest similarity between our population and those participating in previous studies was in race; over 75% of the subjects of all three studies discussed here were Caucasian.

Clinically, we found that over 50% of the children participating in the evaluation of the Family Preservation Initiative scored in the clinical range for aggressive and delinquent behaviors. Further, 43% of the children exhibited attention problems and 36% had problems related to thought disorders.

After receiving informed consent from the participants, demographic information, a Child Behavior Checklist (Achenbach & Edelbrock, 1991), and other measures were collected by the intake worker from the child or adolescent's primary caregiver. Within two weeks of the intake an evaluation team member telephoned the primary caregiver and collected information which included the FES and Family Satisfaction Questionnaire.

The FES consists of 34 items rated on a 5-point Likert-type scale from 1 = not true at all to 5 = very true, designed to measure two dimensions of a family's empowerment, empowerment related to various system levels and the manner in which a family expresses empowerment.

Results and Discussion

Though the demographic characteristics of our population were very different from the previous populations examined (Koren, DeChillo, & Friesen, 1992; Singh et al., 1995), the factors derived were very similar; three factors were derived which were almost identical to the four factors derived by Singh et al. (1995; see Table 1). The major difference was that the present solution has three factors while their solution had four factors, and the items in the factor they labeled knowledge were distributed over the self-efficacy, system advocacy, and competence factors for our results. Since only one item (i.e., other than those contained in the knowledge factor) moved to another factor, we used the same factor labels as Singh et al. (1995). Factor 1, self-efficacy, reflects the primary caregiver's perception of her/his ability to obtain needed services from the children's mental health system for her/his child. Factor 2, system advocacy, represents the primary caregiver's opinion on how effectively she/he can be an agent for change in the children's mental health system, and Factor 3, Competence, refers to the primary caregiver's feelings of competence as a parent. The items that moved from the knowledge factor seem to have moved to related factors (e.g., the items that relate to knowledge about system advocacy seem to have moved to the system advocacy factor).

Based on our results, the three factor solution was the most suitable, because it was most conceptually meaningful and the statistical properties were sound. The solution explained the statistical properties were sound. The solution explained 42% of the total variance and the alpha coefficients for the factors indicate substantial internal consistency. However, the Pearson product-moment correlations among the three factors are moderately high with all the correlations being significant at the $p < .001$ level. This moderately high correlation of all the derived factors indicates that the factors are not independent (see Figure 1).

The FES has been characterized as being a useful tool for longitudinally evaluating programs intended to assist family development related to the acquisition of knowledge, skills, services, and resources from the mental health system for children (Singh et al., 1995). We view this assertion very cautiously for two of the derived factors. An examination of Figure 2 demonstrates that the self-efficacy and competence factors are highly skewed to the upper end of the scale for this baseline measure. This indicates for our evaluation that it will be extremely difficult to measure increases in these dimensions of empowerment should they occur; also, a regression to the mean may even be expected. The system advocacy factor, however, is more evenly distributed, and it may be much more useful for measuring change over time.

Finally, we examined the relationship of perceived family empowerment to various demographic, behavioral, satisfaction, and risk variables (see Figure 3). Significant differences were found between the highest scoring and lowest scoring primary caregivers on the FES for three variables. Belief in the proposition that the family and child will be unconditionally supported in services and satisfaction with services were related to higher perceived self-efficacy and ability to advocate for improved children's mental health services. High levels of perceived child behavior problems were highly associated with feelings of lack of competence in child rearing. If we assume that these associated variables are situational and subject to change in either a positive or negative direction, then it is also possible that the aspects of family empowerment measured by the FES are also situational and not developmental. We will be examining this possibility as we track this evaluation group over the next two years.

The FES, as with all the measures described in this study, measure the primary caregiver's perspective. There have been no independent observations made. However, in discussions with therapists who provide direct services, they have noted that their impressions of the empowerment of the primary caregiver, especially as it relates to competence as a parent, may be very different from the perspective of the primary caregiver. This is an indication that independent observation of primary caregivers will be necessary to measure their levels of empowerment and changes in actual behavior.

The data presented here is from the interviews that were completed within two weeks after intake and are based on only the first 100 families evaluated. Therefore, the results are preliminary and the data will be reanalyzed when there is a larger sample to draw from which will provide a more stable factor solution. These families will be interviewed again at 6 months, one year, and two years from the time of intake to determine if they are experiencing any developmental changes in their reports of empowerment.

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Chapter 6

Interagency Development & Evaluation

Interagency Consultation in Rural Vermont: A Model for Serving Students with Serious Emotional Disturbances

Authors

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Introduction

The prevalence of youth demonstrating serious behavior problems continues to grow at an alarming rate, creating a tremendous challenge for our schools and communities (Sixteenth Annual Report to Congress, 1994). Given the dramatic cuts in human services for children and adolescents, there is a growing need to identify alternative models for delivering effective and accountable services for youth and families with fewer resources.

The Community Collaboration Project represents an effort to maximize resources within one community in rural Vermont by creating an interagency consultation model designed to maintain students with SED in their local schools and communities. The principles of "Wraparound" were applied to create community based consultation practices and interventions that were interagency focused, family-centered, individualized, strength based, preventative, and reflective of multiple life domains (Burchard & Clarke, 1990). The model emphasized consultation instead of direct service in order to serve a greater number of children and families and create broader systems change.

Model Overview

The foundation for this project was an Interagency Support Team (IST) which provided consultation and training to community teams, focusing on both the individual student and broader systemic needs. Project funds were used to gain release time for four members of the community: (a) family consultant &endash; a parent of a child who has experienced a serious emotional disturbance; (b) education consultant &endash; an educator representing the three supervisory unions in the county; (c) mental health consultant &endash; a clinician associated with the local community mental health center; and (d) social services consultant &endash; a representative of the district's social services department.

For twenty hours per week, these four individuals were released from their current responsibilities to serve as the region's IST. The IST met regularly with the county's directors of mental health, social services and education to review patterns of need and identify policies and practices that posed barriers to effective inclusion of identified children and youth. To foster systems change on multiple levels, the IST spent its first year designing and conducting a community needs assessment and action planning process. Based on the information from this process, numerous workshops (e.g., collaborative teaming, conflict resolution, developing interagency coordinated service plans, and family advocacy) were offered on a regular basis throughout the county. In addition, the project was involved in the reorganization of community governance to better serve children and families. Concurrently, the IST provided consultation to community-based teams on issues concerning individual students and broader systems level concerns. The primary focus of this summary will be the consultation provided to community teams.

Methods

Participants

This project was implemented in Addison County, Vermont, a rural region in central Vermont, with a population of approximately 33,000. Three school districts, composed of 5161 students (grades K-12), received services. At the start of the project, 67 children and adolescents in Addison County were in out-of-home placements.

Referrals for consultation around both individual students and broader systems issues were accepted. For individual student referrals, the major criteria for acceptance included: (a) the student must be identified as having an emotional and/or behavioral disorder (as defined by either the special education definition or ACT 264 legislation, 1988); (b) the student must be at high risk of removal from his or her home, school, or community; and (c) there must be a willingness on the part of those involved to work together as a team, with the objective of trying to maintain the student within the community. With respect to system referrals, the criteria included: (a) the system's issues must impact on students with SED, and (b) there must be a willingness to work in a collaborative teaming fashion.

A total of 16 referrals were accepted involving 12 individual students and 4 broader systems issues. Individual referrals involved students in grades K-12. The families of these students reflected predominantly low socio-economic backgrounds (i.e., relatively low incomes, educational, and occupational status); over one-third were single parent homes, and one-third of the students were involved with social services. Of the systems' referrals, two came from special education staff, one from an early education program, and one from the staff at the local community program, and one from the staff at the local community mental health center.

Project Interventions

Two project staff were assigned to each referral. For individual student referrals, the initial step included the formation of a planning team whose composition minimally included the student, the parents, educators, and service providers from relevant agencies. Weekly team meetings were encouraged to reinforce a preventative focus. Emphasis was placed on ensuring that parents were equal members of the teaming process. The second stage involved a comprehensive ecological assessment to gather background and current information reflecting all aspects of the student's life. The team focused on determining the student's strengths, as well as areas of need. Based on this information, a comprehensive plan was developed that built on these areas of strength, and addressed the needs of the student, the family, and the service providers. Resources were pooled from all of the involved agencies. Plans were monitored on an ongoing basis so that modifications could be made as necessary. The length of intervention varied according to the needs of the student and team.

System referrals also made use of a collaborative teaming model, with all key persons involved and meetings held on a regular basis. Similar to the process for individual referrals, an initial comprehensive assessment was completed to determine both the strengths and needs of the team members and the system aspects involved. Duration of intervention was dependent on need.

Evaluation Measures

Both quantitative and qualitative evaluation approaches were used to assess the efficacy of this model. With respect to the quantitative evaluation, all members of the team were given instruments to complete on a pre-post basis. The Consultation Satisfaction Questionnaire was used as a post assessment. All of the measures listed below were administered for individual student referrals. The Teaming Satisfaction and Consultation Satisfaction Questionnaires were given for systems referrals.

- Demographic Survey: assesses socio-economic indicators with respect to the student's family; completed by the parent(s).
- Child Behavior Checklist (CBCL; Achenbach, 1991), completed by the parent(s); Teacher Report Form (TRF; Achenbach, 1991), completed by the teacher(s); and Youth Self Report (YSR; Achenbach, 1991), completed by the youth if age 11 years or older: behavioral checklists used to obtain a global assessment of the student's emotional and social functioning.
- Family Support Scale (Dunst, Trivette, & Deal, 1988): a measure of perceived family support completed by the family.

completed by the family.

- Academic records: attendance, suspensions, academic performance, and achievement scores.
- Parent Satisfaction Survey and Youth Satisfaction Survey: both designed specifically for this project to assesses satisfaction with all services received; completed by parent(s) and youth respectively.
- Teaming Questionnaire: designed specifically for this project to assess satisfaction with the teaming process and interagency collaboration; completed by all team members.
- Consultation Satisfaction Questionnaire: designed specifically for this project to assess satisfaction with the services of project staff; completed by all team members.

The qualitative component of the evaluation consisted of semi-structured interviews with all team members for three select students to explore systems issues in a more in-depth fashion.

Results

Quantitative

According to the data from the CBCL, TRF, and YSR, significant pre- and post- differences ($p < .01$) were noted only with respect to teacher perceptions (see Table 1). In particular, significant decreases were reported on scales relating to externalizing problems (e.g., aggressive behavior and/or delinquency). No significant change scores were noted for the Internalizing scales on the TRF, nor for any of the broad-band scales of the CBCL or YSR. Data on academic performance is yet to be analyzed.

Based on the data from the Family Support Scale, there was a trend towards increased social support from both informal (i.e., extended family and/or friends) and professional resources. While this change score did not meet the traditional $p = .05$ cut-off, the p score of .10 is significant for this small sample size. Significant increases at $p < .05$ were also found with respect to almost all individual items on the Parent Satisfaction measure (see Table 2). Regarding teaming, parents felt more listened to, more involved in decision-making, more respected by other team members, experienced more equality as a team member, attended more meetings, and were satisfied with their child's progress. Increases in overall satisfaction and satisfaction with their family situation were noted at the $p < .10$ level. On the Youth Satisfaction Measure, the only significant item was an increase in perceived choice of services ($p < .05$). Overall, there was a high degree of satisfaction with project involvement from youth, parents, educators, and other service providers. On a 5 point Likert-type scale of Consultation Satisfaction, the mean group scores were as follows: (a) parents, 4.1; (b) youth, 5.0; (c) regular educators, 4.4; and (d) special educators, 4.3.

In terms of educational placement, at the time of referral, 10 students were served in their regular public school mainstream program, 1 was home-schooled, and 1 was served in an alternative education program within the regular public school. At the end of the project, 10 students were served within the regular public school, one was in an alternative education program, and one student was placed in a residential school.

Qualitative

The qualitative interviews complemented the above results. Consistent pro-active team meetings were viewed as a critical component in the success of a student's planning effort. Parents emphasized the importance of being viewed as equal team members, with equal decision-making power. The most successful efforts gave considerable support to the direct care providers (i.e., families, teachers, individual assistants, mental health workers, and social workers). Interagency composition of the team, willingness to share resources, and flexibility in planning were also associated with a greater likelihood of student success. The nature of the student's behavioral disability did not appear to be predictive of outcome.

Discussion

Based on these preliminary results, it appears that the interagency consultation model has the potential for being an effective use of resources for supporting children and adolescents with severe emotional disturbance within their local schools and communities. In this time of limited funding for education and human services, we can no longer afford to operate as independent agencies, each developing and implementing separate plans for youth and families. Through this model, agencies and families are encouraged to work together, building the capacity of direct line workers and maximizing the resources within a community.

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The Access Vermont Initiative: An Investigation of Team Development in Two Vermont Catchment Areas Providing Services to Children with Severe Emotional Disturbances and Their Families

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Introduction

This study was designed to document the processes and dynamics associated with the development and functioning of two multidisciplinary teams created in response to the Access Vermont Initiative.

Interagency and multidisciplinary teams are not new entities. During the past few years, researchers, health care professionals, educators, and business people as well as others, have voluntarily and/or been mandated to form working teams. The logic supporting the formation of teams is that, theoretically, a group of people pooling knowledge, experience, resources, and energies should be more productive, produce a more comprehensive product, and be more cost efficient. In short, a positive and synergistic effect is expected.

Much has been written regarding the hypothesized benefits and efficacy of the collaborative and multidisciplinary team and "system of care" approach to the treatment of children with severe emotional disturbances. However, there is a paucity of research related to the processes and dynamics associated with interagency team development and growth.

O'Looney (1995) distinguishes between the two terms "collaboration" and "service integration" that are often used interchangeably in literature. O'Looney defines collaboration as the processes or dynamic associated with a system and which serve to promote integration; whereas service integration is defined as the system itself. Existing literature has tended to focus on the system rather than on the process. The processes related to collaboration include shared goals and leadership, the development of negotiation skills, consultation, conflict resolution skills, egalitarianism, interpersonal relations, and a respect for, value of, and empowerment of all team members. O'Looney (1995) further suggests that a successful collaboration will involve a relinquishing by individual members of a measure of autonomy and the development of a more global and less personalized agenda or perspective; a process that might prove threatening for some team members.

The current researchers suggested that a historical and almost biographical account of the developmental experience of the two Access Vermont teams would identify a pattern of growth, a dynamic unique to each team, as well as elements shared in a team experience. This study, therefore, focused on the process rather than on the system.

Background

In January, 1994, the State Interagency Team invited Local Interagency Teams to participate in an initiative designed to "promote family preservation." Local team coordinators were asked to convene a meeting of families and regional service providers to develop a plan for promoting family preservation including a supporting management structure (a Stakeholders' Team), and submit this resulting proposal in application for financial assistance (Access Vermont funding). From this initial planning meeting, regional or stakeholders' teams would evolve whose responsibility it became to oversee systems and financial planning, program and human resource development, and also to monitor and evaluate outcomes resulting from the implementation of the community plan. Twelve catchment areas throughout Vermont were awarded Access Vermont initiative funding.

Part of the expectation at the state level was that various service organizations involved in serving children with serious emotional disabilities and their families would collaborate in order to provide a more comprehensive and efficient mental health service delivery system. This increased efficiency would be facilitated by providing a multi-access point of entry to services. The initially contacted agency or service provider would offer to contact the appropriate agency or agencies for the family and thus provide a point of access to multiple services.

The plans submitted by both of the two community teams described in this study included the stated objectives of:

- A reduction in numbers of children placed in state custody;
- the promotion of family involvement in the development of plans for services; and
- the development of a referral process involving a multi-access point of entry.

Both of these catchment areas serve quite large geographical areas. Both regions experience relatively high rates of unemployment, child poverty, teen pregnancy, and child abuse compared with other Vermont regions. Working members on the Stakeholders' Team in both catchment areas included a member from Mental Health Services, Youth Services, Drug and Alcohol and Social Rehabilitation Services (SRS). Additional members on Team II included delegates from the Police, Education, the Department of Health, Domestic Violence and one active parent participant. Team I included only one additional member, a local hospital administrator. Two working team members served as representatives on both Team I and Team II. Interviews were also conducted with two former members of Team I, including a member of the local Police force and a parent representative. Both Stakeholders' Teams have been meeting for less than a year, but many members of these smaller teams were involved as members in the larger Governance or Access Planning Teams.

Method

The researchers investigated the experience and perceptions of Stakeholders' Team members using a qualitative methodology. The principle source of data involved the use of a semi-structured interview format. Team members were interviewed either in person (6 participants) or by telephone (10 participants) and were presented questions related to team involvement and experience as well as their perceptions related to degree of collaboration associated with the team. Secondary sources of data included field notes and investigator's observations resulting from attendance at Stakeholders' Team meetings, team meeting minutes, and planning applications. Participants' interviews were taped, transcribed, and coded by two independent raters, and resulting themes were recorded.

In this pilot study, three researchers conducted the interviews, collected field notes, and reviewed minutes and funding proposals (see Appendix for interview questions).

Results and Discussion

These two Access Vermont management teams were in the early stages of development. This study, then, may serve as a building block for future investigation into ongoing team growth and process. Members from both teams reported that team building is a process; three members from Team II described this process as evolutionary. When asked whether or not the team was fulfilling its purpose or goal, one member responded, "I think that question is premature at this point. The team and its goals are evolving and in a very positive way."

As the transcriptions were analyzed, five prominent themes emerged which spoke to the research question regarding the development of team unity and collaborative processes:

1. Issues of trust.
2. Professional and personal networking.
3. Unifying goals and a common vision.
4. Communication and negotiation skills.

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5. Inclusive community representation.

1. Issues of Trust

Trust is a transactional construct involving a sense of the value of the contributions, experience, and knowledge of another or others who in turn reflect this confident reliance. Trust necessarily springs from a shared sense of security and faith and that one's beliefs and priorities will not be betrayed. Without the element of trust and the positive perception of interdependence among and between team members, the collaborative processes will be impeded. Previous research considering interdisciplinary collaborative efforts have identified issues of trust as being paramount to team development (Blechert, Christiansen, & Kari, 1987; Melaville, Blank, & Asayesh, 1993; O'Looney, 1995). Territorial or competitive attitudes were identified by both teams as early obstacles inhibiting feelings of trust.

A voice from Team II articulated this theme:

"I think there's enough trust in the group that people have been able to put things on the table and deal with them as they come up."

A second voice from the same team:

"Most of us that have been on this team had been on other teams together, so we've built up our relationship from there. I think we had already established a level of trust necessary for really the type of team that we have now. So, I think that it was really our own experience on other teams in the community that really helped us in our collaborative process. We're open to listening to each other's perspectives and willing to change our own.

Confidentiality is basic to the development of trusting relationships. A parent identified her feelings of lack of inclusion as a member of one team as directly related to the team's failure to invest trust:

"I was a bank manager &endash; confidentiality is one of my better things. I'm on the school board. I have an autistic child. I work with special education. There's a lot of issues related to confidentiality that I've lived through. If you don't trust the parent, then there's no sense in having them on your committee."

Trust and confidence at the state and client levels were addressed. It appeared that the consolidation of trust at the team level made increasingly apparent the need for the development of trusting relationships at multiple organizational levels.

One voice addressed the need for state administrators to demonstrate faith in the competence of local teams:

"I think giving as much information as is known. So being

"I think giving as much information as is known. So being really forthrightÉ not having hidden agendas. If you know something's coming down the pike, just tell us something's coming down the pike. And we'll deal with it. And also respecting our ability to deal with issues."

Team members also expressed the need to extend this atmosphere of faith to the families they serve:

"I think most people really do feel that people [families] need choices so that people are able to pick who's best able to meet their needs. And I think we need to trust in people's ability to figure out what they need."

2. Professional and Personal Networking

O'Toole and Montjoy (1984) operationalize networking as "the actions of people working together on specific tasks that solidify collaboration and build a sense of interdependence that many who have studied collaboration identify as a key ingredient in multi-action implementation" (page #). Many informants identified networking and task sharing as critical contributors to team unity.

"I think bringing people together to discuss common issues and concerns and offer opportunities to brainstorm and to work out problems [promotes team unity and benefits the target population]. And I think there's other things which obviously evolve from that &endash; support to families, support to the community, to school personnel, and therefore it increases the understanding, the patience, and the support by having the appropriate people involved."

Provision of a forum in which to disclose and share personal and professional frustrations prompted a spirit of networking:

"Just getting things in place and talking to each other and working out the bumps. Everybody has kind of hung in together and there have been times when we all want to pull our hair out but people have continued to just sit down and talk to each other and put it on the table and say, 'This is what's making me crazy and can we do something about this.' And we've seemed to be continually doing that and able to do it and that's very satisfying."

A second individual described networking as pieces of a puzzle coming together to create a more efficient whole.

"I don't think any one of us provides what every family needs. Even if we had unlimited funds, I don't think any one agency, group, church, religion, or whatever group we come from can be all to all people. Who can offer what piece and share information with each other so we don't go off on tangents. If we were in our own little worlds, I think we'd duplicate more."

Collaboration includes a relinquishing of some portion of personal or professional status or position, a resolution of personal or professional status or position, a resolution of territorial issues, and an adoption of a team identity. Networking, an important component of team building processes, appears to promote creation of a team identity, as well.

"I think it's going out into the community together. It's developing that identification as being Access, and you tend to stop identifying yourself as SRS or Mental Health and you start identifying yourself as Access and that's an important component in collaborating and team building and not only for the team itself, but within the community and among those agencies."

3. Unifying Goals and a Common Vision

Research in team development and multi-agency collaboration has emphasized the importance of shared goals and a common vision (George, 1987; Mattessich & Monsey, 1993). The emergence of a shared mission or an ideal is an integral part of the process of team building. As Senge (1990) points out:

"Visions that are truly shared take time to emerge. They grow as a by-product of interactions of individual visions. Experience suggests that visions that are genuinely shared require ongoing conversation where individuals not only feel free to express their dreams, but learn how to listen to others' dreams. Out of this listening, new insights into what is possible emerge."

These wisdoms were echoed in the transcribed experiences of group members. One group member responded:

"I think that's a place that we're coming to. . . to begin to describe a vision. I think that we're all moving in the same direction, but I can't really say that &endash; 'Yes, absolutely we are and this is our vision.' That's the kind of developmental place that we are. I don't feel like it's something that's lacking. I think that we've been busy doing other work and that we're now at a point where we can step back and say &endash; 'Okay, where are we going ?' and 'What's our vision?' I think that goes back to my desire for some time for planning and thinking and dreaming about what we are going to do and how we are going to be most effective. Personally, I would like to try to involve kids and families and the community together in a way that incorporates kids more in what's going on, so that they feel valued, and they feel wanted and feel they have a stake in the community and a stake in being here."

Although common goals and a unifying vision have clearly been identified as essential in team development, they are also part of a growing process. Team members recognized that a sense of mission is not static, but rather it evolves with maturity. One informant defined the vision as:

". . . a little bit fuzzy right now [but describes] a sense that there's something bigger out there that we need to reach. . .

there's something bigger out there that we need to reach. . . to go beyond and to reach some of the outcomes that we're talking about, because otherwise I think we're just going to keep doing the same thing."

4. Communication

The fourth theme, communication, has been identified in research as essential to team cohesion (Chafetz, West, & Ebbs, 1988; Mattessich & Monsey, 1993). Communication was defined as the channels through which information is disseminated. Effective communication is characterized by inclusive and respectful sharing of pertinent information.

Participants informed us that it is not only intrateam communication and information flow that impacts on team effectiveness, but equally, the channels carrying information between state and local levels. Team members called for communication clearly delineating and defining expectations and boundaries.

"If actions initiated at the state level are just going to be countermanded later on then it's not going to be very worthwhile to put in a lot of effort at the local level. It's a waste of time. So getting direction up front and honest clear guidelines of what is going to happen is very worthwhile. 'What are the objectives? What is the point of having the team? What are the parameters of our authority?' Really define things and being really clear about what we are addressing."

Reiterating this concern related to state and local lines of communication, this participant used the example of a proposed announcement calling for redistricting as indicative of poor communication.

"For Governance Boards not to know about that, I think is unconscionable and it says that [it is assumed] that their maturity is not at a level where they can handle that information. We need to know [state expectations and projections] right from the start. What is it that the state will give to communities?. . . People began to be frustrated about what the state's vision of local control and community planning was. Are there limits to what you can do? Are there expectations from the state regarding goals and objectives? I think there are very definite expectations they want to see met, but they've not communicated that to us."

At the intrateam level, effective communication was also identified as a predictor of group cohesion. Participants revealed:

"I think that there are a couple of primary players. . . I think that those people need to let go a little bit and communicate better with our team in terms of [the information] that the state gives. A lot of times when we go to the meetings there are two or three people who really know what's been sent and really have a handle on what's going on. They're not really good at getting that information disseminated to the really good at getting that information disseminated to the rest of the group. . . I don't know whether it's because they need to control the information or they just need to make things happen. Sometimes it's easier to say 'Oh I'll do it myself because that's a quicker way to make things happen.' But, it doesn't do the team building piece."

This observation was confirmed by other respondents:

"It seems that by default. . .that [one person] has access to a lot of information. It is that [person's] interpretation of information that we get and I do feel that that is not appropriate. I believe that as team members we should all have access to the same information."

"I think dissemination has been a problem. Since there isn't a coordinator for the team, a member of the team who already has another job is getting the information and then has to fit in time to mail out sometimes rather large volumes of paper. So, it doesn't always get out in as timely a manner as would be helpful."

5. Inclusive Community Representation

Part of the Access Vermont Initiative calls for representation reflective of the local catchment area population. Mattessich and Monsey (1993) recommend that "the collaborative group includes representatives from each segment of the community who will be affected by its activities". This theme was prominent, poignant, and recurrent.

"I think that teams have to like to work with parents. . . Specialists seem to think that they give the service so that they know more about things. Most parents feel inferior. . . some committees only want parents' signatures to show that they're trying to work with parents, but they don't really care what parents think. Professionals [need to] become human. . . to put themselves in the parents shoes and not just look at their books. Parents' voices are valuableÉ they have to listen to parents and make them feel a part of the team not make them feel they have to be there because that's how they get grants. So, they don't really want the parents' participation, but the state says, 'You really should have parents; you should listen to what parents want and stuff.' How's that for honesty?"

For their part, professionals are beginning to recognize that team environments can be uninviting and threatening to non-professionals. One agency member reflects:

"It's been a real difficult test [inclusion of parents] and we still have a lot more to do to make this process more attractive to families. We have to create an environment where youth and family people feel safe coming to a meeting. I feel uncomfortable in a room full of bureaucrats, and I think we have to be sensitive to what that feels like to families."

Although there appeared to be a general consensus regarding the need and desire for increased representation, it also appeared that the achievement of this goal will require significant and sensitive commitment from involved professionals. Recognition of the complexities associated with more inclusive representation have perhaps worked to delay realization of this goal. Team dynamics might be predicted to change as new members come on board, and it would be necessary for the language of the team to be accessible to all. One professional contended:

"There are not enough parents in the group. I think everyone agrees that there needs to be more people, but it will be interesting to see how the dynamic changes. In the long run, I think we can function without more community representation, but certainly we'd get a broader-based view when we add [people]. You know, you bring in different people from different areas and they have different perspectives."

A parent reflected:

"It was like I was taking up too much of their time. Before you can make a comment about something, you have to know what they're talking about. They did not want the bother of explaining to a parent that had been through just part of the system. . . I think the state level is very high on encouraging parents to participate. . . Instead of giving trainings to the parent all the time, give some to the professionals. What does it mean to have a parent in the group? What do you expect from a parent?"

We summarized the essence of these comments with the recognition that these teams are in the early stages of development and will inevitably evolve over time. In the words of one member:

"Two years from now it may not look like what it does now. That's kind of the exciting part of the whole thing. So, we just keep moving."

Conclusion

The purpose of this project was to explore the development of two Vermont Stakeholders' Teams formed to respond to the Access Vermont Initiative. The researchers had hoped to draw from this developmental account an understanding of the dynamics associated with collaborative efforts. It was proposed that identification of variables influencing the team process might serve as a tool for the development of a learning model or source of reference for future teams. Awareness of the multiple variables influencing a collaborative team process and dynamic is critical to opening the process to potential mediation and consequent modification. This enhanced awareness may also allow a team to move beyond temporary obstacles inhibiting effective collaboration to a realization of its full and most productive potential.

productive potential.

Although five predominant themes were identified from the data, the individual themes themselves appear to call for continued investigation. Future research questions might include &endash; "What are the precursors or antecedents leading to the establishment of trust in intrateam configurations?" and "How are intrateam trusting relationships maintained?" Future studies might also investigate the effect of crises such as economic change on team dynamic. The movement toward integration and inclusion of non-professional participants also calls for exploration. Both professional and parent representatives identified parent membership in these two teams as problematic, and future studies should address clear definitions of the specific barriers to parental involvement. Researchers speculate the team members' difficulty in articulating these barriers may reflect the teams' early stage of development. Many participants, both professional and non-professional, identified increased parent participation and non-professional involvement on teams as critical to future team success. Members offered thoughts regarding ways to increase inclusion and resulting cohesion; these included provision of opportunities for parent networking and professional training highlighting the value of non-professional resources. A clear identification of obstacles to inclusive representation might aid the design of such training structures.

This study is limited in that only two Vermont teams were included in the analysis, and in that these teams are truly in the early stages of development; their current status may not reflect future developmental patterns. However, research designed to follow these and other teams longitudinally may prove revealing.

The value of this study lies with its contribution to the literature on team process. Future directions might lead to the development of a quantitative instrument designed to measure process and progress in interdisciplinary team evolution. Ongoing qualitative work will serve to inform future quantitative research with regard to issues relevant to productive team functioning.

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Appendix 1

Stakeholders' Team Interview Questions

1. What do you see as your role as a working team member?

2. What are your personal reasons for involvement with this team?

3. What do you see as the purpose of this team? How is (or is not) the team fulfilling this purpose or goal?

4. What are the personal rewards or benefits of affiliation with the team? How does your target population (children with serious emotional disabilities and their families) benefit from the presence of this team in your community?

5. From your perspective, does your team provide for a fair distribution of responsibilities, roles, resources, and credit for accomplishments? Is its structure hierarchical or egalitarian? Are there defined leaders on the team or is leadership shared?

6. Do you feel that your team was given guidance or direction related to the formation of a working, collaborative team? If not, do you believe guidance would enhance team function? If so, what was the nature of the guidance or intervention? Did this guidance or intervention affect your team's collaborative effort?

7. Have there been obstacles or barriers realized in the process of building the team? From your perspective, what has been the most significant obstacle to team development? How have team members worked to address and surmount these obstacles?

8. Can you identify problems or conflicts that your team has encountered? When problems or conflicts have arisen, how has your team worked to resolve them? Does the team address the problem directly and openly or does it appear that it is the nature of the team to leave the problem or conflict unaddressed?

9. Have you experienced or recognized competitive or territorial attitudes among or between members of your team? If so, in your view, how have these attitudes affected team function? How do you personally deal with territoriality?

10. Do you feel that each team member is respected or valued and her/his voice heard at meetings?

11. Can you identify any issues, events, or situations that have contributed to team cohesion and cooperation among members?

12. In your view, how can collaboration be improved? What actions might be taken to enhance team unity and cooperative spirit among and between team members?

13. How can individuals or collaboratives at the state level facilitate interagency collaboration at the local level?

14. Do team members appear to have a common vision for improved services to severely emotionally disturbed children and adolescents and their families?

15. From your perspective, do you feel the team works effectively? Do you see yourself as part of a team?

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Developing an Effective Statewide Network: Outcomes of Florida's System of Care for Students with Severe Emotional Disturbance

Authors

Introduction Method Results Discussion References

Introduction

Children in the education system with complex needs, at risk of costly institutionalization, present natural opportunities for cost-shared, collaborative planning, and service coordination. Many of these students may also be children served by the child welfare system, office of mental health services, and/or the juvenile justice system.

During the 1979-80 school year, Florida's public schools contracted for 72 residential placements of students with severe emotional disturbances; during the 1980-81 school year, 83 such placements were made prior to February of 1981. Total contract costs for these placements ranged from about $1,000 to over $248,000 per student. As a result of the increase in contracted services for residential placements by public school systems and the identified need for community based mental health services, the Bureau of Education for Exceptional Students, Division of Public Schools, Department of Education (DOE) was given the responsibility for conducting a study to determine the need for services for students with severe emotional disturbance (DOE, 1981). In February, 1981, a Report of the Study to Determine the Need for Educational Centers for Emotionally Disturbed Students was prepared for the Commissioner of Education. This study provided the information essential to the Florida Legislature to develop the Multiagency Network authorizing legislation.

The study found that the majority of children who were in state-funded residential treatment were being served in programs outside the State of Florida, and that 75% of Florida's children's mental health funds were being spent on residential treatment. Very few exceptional student education programs existed for students with severe emotional disturbance. There was only minimal community-based multiagency service planning, coordination, or delivery. Consequently, children's mental health services were inadequate with virtually nothing to fill the void between outpatient care and hospitalization. It was also determined that the family involvement in children's mental health planning and programs was minimal or non-existent, and communication was limited across programs or agencies. There was limited cross program training, and any efforts in assessment were redundant and not focused. Finally, there was an absence of information and referral services, crisis intervention services, school-based mental health services, and multiagency case management for families.

Method

To address this multi-agency service issue, appointments by the Secretary of Health and Rehabilitative Services and the Commissioner of Education created a State Advisory Board composed of leaders in education, children's mental health, and children's advocacy. Working in an advisory capacity to the Bureau of Student Services and Exceptional Education, a plan to offer fiscal incentive for collaboration was developed and made available to select school districts within each region of the Department of Health and Rehabilitative Services (DHRS).

SEDNET projects were awarded to one school district within each DHRS region, and required signed cooperative agreements between DHRS and each school district. In many regions, projects were funded through the Individuals with Disabilities Education Act (IDEA) Part B, General Revenue, and local contributions. Each project was staffed by one full time project manager and various support staff. To date, over five hundred leaders in education, health and human service systems, mental health centers, parent coalitions, and juvenile justice entities voluntarily serve on regional SEDNET Advisory Boards.

Florida initially developed an urban and rural model in 1982-83. Pilot sites demonstrated the need for local flexibility and control for maximum success. Therefore, a statewide framework was developed requiring locally-determined, needs-based priorities consistent with guiding principles. Statewide network goals included the following: (a) multiagency planning for a complete array of services, (b) continuous improvement of service in the system of care, (c) evaluating the effectiveness of the system, and (d) disseminating information regarding the system of care.

In 1985, DOE contracted with the Department of Child and Family Studies, Florida Mental Health Institute, University of South Florida, to administer the Quality Development Teams (QDT), in order to identify characteristics of successful projects and evaluate SED Network Project impact on the delivery and effectiveness or services to children with SED. Statewide project reviews were conducted and features of quality projects and effective networks with successful outcomes were examined at the networks with successful outcomes were examined at the planning, implementation, and evaluation levels. Multidisciplinary teams looked at what enabled networks to bring their children back to their communities from out of state and county placements, create new special education programs and day treatment programs, intervene in times of crises, provide multi-agency case planning and case management, and have meaningful parent involvement.

Standards and self assessment tools were developed for both the projects and networks, in addition to identification of competencies of effective project managers, board members, and other network participants. Five volumes of best practices were published as additional tools to assist communities in creative problem-solving, and program and professional development.

Florida's legislation authorizing the SED Network was amended in 1990 to include a requirement for annual reporting to the Legislature. Four annual reports have been produced to date, summarizing regional and statewide accomplishments and providing recommendations for further progress.

Results

Although enrollment in schools has grown by 32 percent over the past nine years, according to the March 2, 1995 memorandum to the Senate and House Appropriations Committee1, only 28 students with severe emotional disturbance were in private residential programs under school district contracts during fiscal year 1994-95. This is a reduction of 61%. Similar progress is evident in DHRS placement data, with a significant increase in Florida's ability to serve children in therapeutic foster homes versus more costly residential treatment.

Florida's progress over the last ten years is also evidenced in outcomes of students with severe emotional disturbance. According to enrollment, placement, and exit data, there has been a 60% increase in the numbers of students with severe emotional disturbance graduating from high school. Also, there has been a 25% increase of students identified as eligible for educational programs for youth with emotional disabilities, albeit consistent with the increase in Florida's student population. There are 16% fewer students with SED being placed outside the public school system, and a total of 15% more students with emotional disabilities are being served in regular education classrooms. Finally, there has been a 100% decrease in the number of students who are placed outside the state for residential treatment with children's mental health funds and an estimated 3,000 students were diverted from residential treatment during the past fiscal year through DHRS Family Service Planning Teams.

In 1995, families were more involved and active with multiagency planning at every level than ever before. Due mainly to strong, cohesive groups and organizations, parents had opportunities to be active partners in planning and service delivery. This has resulted in policy enhancements and changes that impact favorably on Florida's students with severe emotional disturbance. The SED Network has assisted in the growth and development of organizations, such as The Florida Alliance for the Mentally Ill - Child and Adolescent Network (FAMI-CAN); The Florida Federation of Families for Children's Mental Health (FFFCMH); and The United Families for Children's Mental Health (UFCMH).

Network projects now boast 100% family attendance and participation in Family Service Planning Team operations, where multidisciplinary case plans are developed, case managers are designated, and integrated service plans are agreed upon by the significant participants in each child's life. In addition, family members serve on the State Advisory Board and on 17 of the 18 regional, multiagency advisory boards.

Discussion

By providing staff support, the DOE creates opportunities for school districts to unite in a regional structure consistent with the DHRS, fiscal agents for children's mental health funds. This approach has resulted in a rich diversity of decentralized structures and approaches, reflecting local decision-making that builds on community leadership and resources. This structure also allows for the maximization of scarce resources, supplementing the capability of a single county school district.

According to the Florida Children's Mental Health Plan (annually required for federal block grant funds), $228 million was spent on children's residential treatment services in 1995-96. The benefits of these funds is maximized with state, regional and locally integrated planning, implementation and evaluation. The total cost of the Statewide SED Network activities which assist with this function, as well as addressing the goal of an integrated system of care, is 2.2 million annually. During the 1995-96 legislature session, a 190% increase in General Revenue was allocated for SEDNET. As a result of an increased awareness for the needs of youth with emotional disabilities, advocacy, and research demonstrating the effectiveness of early intervention, Florida has (a) increased its budget for children's mental health by one million dollars in the last decade, (b) increased the number of children served by 78%, (c) reduced the expenditures per child by 73%, and (d) decreased the number of residential treatment from 29.3 days per recipient, in 1992, to 14 days, in 1994 or 52%.

The role of the state is to provide statewide coordination, identify and replicate effective practices, and provide technical assistance and eval-uation. Multiagency networking contributes to student graduation, increased recognition of program and service eligibility, greater inclusion, improved access and effectiveness of the system of care, family involvement, and a broader array of community-based education and treatment alternatives.

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Utilization and Effectiveness of Florida's Multidisciplinary Family Service Planning Teams

Authors

Introduction Method Results Discussion References

Introduction

In Florida, Case Review Committees (CRCs) were developed in the early 1980's to be the gatekeepers of residential placement for children with emotional disabilities. There were, however, over 400 children statewide on CRC waiting lists, and no identified planning mechanism to maintain those children in the community awaiting placement or to divert children from CRCs. The Family Service Planning Teams (FSPT) were initiated in 1987 by the Office of Alcohol, Drug Abuse and Mental Health, Department of Health and Rehabilitative Services (DHRS) to accomplish this purpose.

FSPTs were implemented not as a result of new funding, but from a commitment of DHRS and the Department of Education (DOE) to create interagency planning forums to develop holistic service plans to enable children to live in the community and be successful in school. The Multiagency Network for Students with Severe Emotional Disturbance (SEDNET) was established by the Florida Legislature in 1981 in recognition of the significant cost and lack of progress of students served outside the state in psychiatric residential treatment. SEDNET project managers, already functioning as regional network coordinators throughout Florida and funded by DOE, became the facilitators of this new planning effort. FSPTs have become the focus of service planning for children at risk of out-of-home or school placement in need of multiagency involvement, bringing together parents and social service and education professionals.

Since implementation of FSPTs, many of the children previously in out-of-state residential treatment have been able to return to Florida. Referrals to CRCs have decreased. Concurrent educational program development and multiagency cooperative systems of support have promoted educational reviews of clients of DHRS resulting in a 260%

increase in student eligibility and in services provided through educational programs for students with severe emotional disturbance. Multiagency case management services have simultaneously increased, as have parent/professional partnerships, access to Medicaid, and private contributions to local systems of care.

In response to continuing needs for improving implementation, identifying training needs, and supplying additional data on this pre-residential intervention, a multidisciplinary planning team review was conducted.

Method

The multidisciplinary planning team review was conducted in three parts. Part One focused on the utilization of services by the FSPTs. SEDNET Project Managers were asked, "What services purchased by the FSPT(s) make the most difference in improving the lives of the children and families served?"

Part Two provided a status report of the children whose collaborative treatment plans were described in one of four Best Practices in Creative Service Delivery manuals (1989-1992). A total of forty-seven cases were selected. Project Managers were asked, "What was the major contributing factor of successful service planning?" and "What was the most valuable contribution of the system to this child?"

Part Three focused on a single county's FSPT efforts to assess the overall satisfaction of the consumers they served. This FSPT also conducted a needs survey to identify those services most frequently requested by parents/guardians. Twenty interviews with parents/guardians were conducted.

Results

Part One

Responses were received from 14 of 18 regional SEDNET projects, representing 50 of Florida's 67 counties (75%). Ranked in the order of making the most difference, purchased services included:

1. Recreational/leisure activities aimed at improving self-esteem & social skill development.

2. In-home services/in-home parent education and counseling/therapy.

3. Respite care

4. Behavior Specialist/Certified Behavior Analyst in school and home

5. Mentor/Therapeutic friends

5. Mentor/Therapeutic friends

6. Case Management

Part Two

Looking at Family Service Plan development process and outcome, SEDNET was able to provide the child's status and residential placement history for sixteen of the forty-seven children. (Children in the Best Practices manual were identified by numbers or initials only. Identifications relied on project manager's or case manager's memory of the child from brief, anecdotal case presentations.) Of these 16, 10 of the youth staffed at FSPT (63%) did not go on to the CRC, although three were placed in residential facilities. Four youths did go on to CRC; three were placed in residential facilities, and one remained at home with support services. Two of the sixteen youths reviewed had already been discharged from residential placement and went to CRC for review only.

In response to the question, "What was the major contributing factor of successful service planning?," findings of the reviews suggest that when the youth did not go on to CRC, there was a consistent individual involved in planning and implementation of service plans. Involvement was primarily with a family member, usually the mother. Other individuals included biological father, case manager, and teacher in an SED classroom. Consistent family involvement was also the common factor with the one child who went to CRC but was not subsequently placed out-of-home.

With the three youths who were placed in residential treatment through the CRC, family involvement was described as less consistent: (a) one child had family involvement in the early years but less involvement after placement; (b) one child with the mother involved, but her own addictions problematic to consistent treatment; and (c) the third child with parents who were divorced but involved and concerned. In the two cases where the youths were reviewed at the CRC, following discharge from residential placement, one family was involved in team planning from the beginning with regular communication with the case manager, while the other family became more involved and participatory as they began to see improvement. The three youths who did not go to CRC but were placed in residential treatment were youths in foster care with no direct family involvement.

When asked "What was the most valuable contribution of the system to this child?," the three most frequent responses were: (a) looking at the family as a unit, (b) keeping the child in the home with in-home services, and (c) multiagency planning meetings.

Part Three

The FSPT in Hernando County endeavored to assess the

The FSPT in Hernando County endeavored to assess the overall satisfaction of the consumers whom they served. These consumers were determined by the committee to be both the children of concern and their parents/guardians. However, only the parents/guardians were surveyed.

The FSPT Satisfaction Survey consisted of 29 statements based on a 5 point Likert-type scale to determine their satisfaction and attitudes toward the FSPT process and actual services provided.

- 74% felt included in the planning of services at the FSPT, wanted to come to the meeting, and be part of the process.
- 58-73% felt they were treated with respect and given the opportunity to speak.
- 64-85% felt that their beliefs, values, and points of view were used to plan services.
- 74-95% felt that FSPT provided good services for children/families.
- 74-95% felt that the goals of the Family Service Plan were explained adequately.
- 36% felt blamed for their child's problems.
- 43% strongly agreed, and 26% somewhat agreed that their children could be helped in the home.
- 63% did not feel intimidated by the process.
- 69% felt that the FSPT committee used the family's day-to-day life to plan for services.

Recommendations based on survey outcomes include: (a) hiring a Parent Liaison to help parents feel less intimidated with the FSPT process and be more of an integral member of the case plan; (b) developing strategies to overcome the transportation barrier and provide more in-home services whenever possible; (c) developing surveys for the children of concern so that their satisfaction can also be measured; and (d) including the children of concern in the FSPT process whenever possible.

The needs survey to determine what services were most frequently requested by parents/guardians consisted of twelve individual categories of services and was measured on a 0 - 2 scale.

- 70% felt the following services were very needed: Case management, recreational activities, one-to-one adult/child relationship (e.g., Big Brother/Big Sister).
- 50-65% felt the following services were very needed (ranked in order of importance): (1) Financial assistance; (2) counseling, family, individual and group; (3) social skills training; (4) evaluations; (5) vocational training/job coach; and (6) home-based services.
- 60% felt out-of-the-community residential services were not needed.
- 45% felt parent education was very needed.
- 45% felt parent education was somewhat needed.

Recommendations based on the results of the Needs Survey included: (a) developing a therapeutic mentorship program; (b) provision of financial support for a child psychiatrist so that medication management, therapy, case management, and non-clinical services can be obtained for Medicaid clients; (c) continued parent education in the community; (d) increased respite in the community for special needs and at-risk children; and (e) continued funding for specialized training/personnel for summer recreation programs.

Discussion

Multiagency case planning has allowed concerned individuals to request that significant partners in a child's life collaborate in the development and implementation of the best possible plan utilizing existing community resources, or with limited availability, new resources. The family-centered, customized approach to service, resource development and coordination on behalf of children who need services from multiple systems has been key to the success of regionally-initiated FSPTs. Multiagency case planning has also provided continuous needs assessment data to program planners for improving the local system of care. With resources at a premium, identifying and providing the services which make the most difference in efforts to assist youth with special needs is more important now than ever before.

The key services identified in this study reflect the concerns of this special population. For example, many students lack initiative, self-discipline, and continuous guidance/supervision, resulting in the need for external support systems to boost self-esteem, as well as to increase their ability to seek out constructive activities for personal growth. Similarly, the ability to provide essential respite care at the time of need has long been reported as a major contributor to parental ability to maintain children with intense needs within their homes. Traditional outpatient services often neglect the ability and potential of the caretaker in shaping behaviors and providing extended support. Counseling services made available to children and parents in their home setting may allow a more complete view of family and environmental dynamics, and contribute to more accessible and effective interventions. Additionally, the study shows that parents, teachers, and caretakers of children often lack the benefit of professionally trained experts in systemic approaches to behavior management. The services of specialists in behavior management, however, not only provide direct assistance with student and child-behaviors, but provide a source of instruction and technical assistance to teachers/caretakers. Also, the value of a significant other has been consistently documented in mental health and delinquency-related research; the use of mentors or therapeutic friends, in volunteer, paid, or Medicaid funded non-clinical in home service utilization is perceived as having made a difference in positive outcomes.

Finally, designating a service coordinator as needed is a key to success in assisting and monitoring the implementation of many multiagency plans.

New funds earmarked for student success and support are available through delinquency prevention opportunities, family preservation, family support, and other initiatives with similar missions. Managers of these funds and prospective providers are encouraged to maintain and/or develop responsive programs, new and creative services, and maximize opportunities for flexibility necessary for truly individualized services.

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The Prime Time Project: Developing an Intensive Community-Based Intervention for Youth in the Juvenile Justice System

Authors

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Introduction

The Prime Time Project is a comprehensive intervention model for youths who are at the extreme end of the juvenile justice continuum due to their history of repeat offending, relatively severe offenses, a high degree of isolation or abandonment from their natural community, and the co-occurrence of mental health disorder. Prime Time was initiated in the fall of 1995 in King County,

Washington. Faced with rising juvenile crime and violence, increasing public concern, and a corresponding rise in demands placed on the county juvenile justice system, county officials have voiced a high level of interest in alternative, or enhanced, services to address juvenile crime. The county council awarded a two-year grant, recognizing that effective interventions exist and that linkages and collaboration between agencies and service providers play a role in successful intervention. The goals negotiated with the county were simple: (a) reduce recidivism, (b) reduce severity of violent and other offending behavior, (c) increase school attendance and performance, and (d) increase residential stability. The county council also mandated that we target those youth in the "deep end" of the juvenile offender population. This translated to the following entrance criteria for youth in the program: (a) currently in detention; (b) age 12 to 17; (c) at least two admissions to detention; (d) adjudicated for a relatively serious offense (e.g., assault, burglary, vehicular homicide, etc.); and (e) presence of a diagnosable mental health disorder.

Theoretical Background

Social-ecological models explain delinquent behavior as multiply determined by interactions between genetic, psychiatric or psychological variables, and key elements of the environment such as family, school, peers, and other systems. Accepting this approach, we found more specific guidance in Patterson's (1982) explication of a "coercive cycle" in aggressive children's antisocial interactions. Patterson described an interaction pattern in which a youth's antisocial behavior is followed by the parent's negative reactions. This, in turn, escalates the youth's antisocial, aggressive behavior, triggering a cycle that is both cause and effect.

With Patterson's model in mind, we noticed a striking pattern of coercive exchanges across a wide range of systems in which juvenile offenders interact. For many of these youths, reciprocal coercive exchanges characterize interactions with family members, teachers and other school officials, and members of the community. Once referred to the juvenile justice system, the youth's interactions with police, courts, detention staff, and probation and parole officials are often coercive in nature. Building on the reciprocal effects and negative reinforcement described in Patterson's model, it followed that an intervention which broke the "coercive cycle" might be effective in enhancing pro-social behavior and reducing offending.

We were also impressed by the success of the Multisystemic Therapy Model of Henggeler and Borduin (1990) and set out to fashion our intervention after their model. Specifically, we sought to design a family-based therapeutic intervention that would integrate affective, cognitive, and social interventions, be community-based, incorporate case advocacy, and involve youths and families in treatment planning and implementation.

Boundary Spanning and Collaboration

In light of the multiple systems in which juvenile offending youth are involved, and guided by Child and Adolescent Service System Program (CASSP; Stroul & Friedman, 1986) principles, we framed program development in terms of the Jericho Principle (Melton, 1989). The Jericho Principle is a metaphor, suggesting that walls should come tumbling down between disciplines, or sectors, of the child and family service system.

Collaboration with Families

Although many families, for both obvious and subtle reasons, are unable to provide consistent support for their children, we place a strong emphasis on collaboration with parents and families when possible. Families are contacted while youths are in detention. Meetings, for assessment, treatment planning and counseling, begin at that point. Families are involved in developing a structured transition back to the community, and in fine-tuning services to meet their specific strengths and needs.

Collaboration with the Juvenile Justice System

The Prime Time Project is based out of the King County Department of Youth Services (DYS) and a nearby community health clinic. Therapist/case managers of the Prime Time Project make contact with youth and families while the youth are detained and then follow them into the community upon release. Through our physical placement within juvenile detention, we have watched and perceived some walls to have buckled, although not totally collapsed, between the juvenile justice and mental health system.

Judges

Close collaboration with judges has afforded us a high degree of involvement in judicial disposition planning. Juvenile court judges refer youths to our program and invite our recommendations as to disposition planning. Eager for an expanded set of options for these troubled youth, judges have enthusiastically welcomed our efforts to demolish the metaphoric wall between the justice and mental health system.

Probation Counselors

Similarly, program staff have developed close collaborative relationships with probation and parole officers. The leveling of this wall has facilitated the design of a seamless approach to behavior management across systems and permitted more consistent monitoring of youth's participation and compliance in treatment, school, or vocational activities. Probation officers have welcomed the involvement of mental health professionals, leading to the construction of detailed probation orders tied to established principles of behavior management.

Collaboration with Police

Working closely with probation counselors, we have found that responding to youths' non-compliance with a warrant and brief detention may serve as an effective container, in both the literal and therapeutic sense. Recently, we have been able to forge a collaborative alliance with local police officials.

Collaboration with Schools

While education represents an important avenue of change for youth in the juvenile justice system, school has often been the setting for repeated failure, both socially and in the classroom. Among participants in the Prime Time Project, few are enrolled in school upon release from detention, and almost all have a history of multiple suspensions or expulsions. Collaboration with teachers and administrators is vital to facilitating youths' re-entry into the education system.

The Prime Time "Day Time" Program: A Transitional Community

In light of the degree to which many youths are extruded from their communities and lack many of the competencies necessary to social, academic, and vocational success, it should be useful to put in place a set of structures to facilitate youths' transition towards broader community involvement. To this end, the Prime Time Project incorporates a series of structured group activities. These activities do not take the place of intensive family-based (when possible), eco-systemic intervention. Instead, they serve as a transitional community for some youths and as an adjunct for others.

Prime Time activities seek to provide additional structure and external control for youths who both have too much time on their hands and too little capacity for impulse-control. Involvement in these activities offers a respite from the youth's involvement in coercive interactions, allowing them to practice alternative, pro-social styles. Some youths benefit from a graduated return from detention (where many report feeling quite safe as a function of the structure inherent in the setting), to the community, where risks are greater and external controls limited. The structured daily activities may serve as the venue for the "in vivo" transfer of vocational, academic, and social skills in a setting located in the community, while featuring opportunities for structured, pro-social interaction. Finally, by designing activities that proceed through a series of stages, youth are given the opportunity to follow a graduated pathway of success experiences leading to increasing community involvement.

This aspect of the intervention takes the form of structured half-day and evening activities located in a local community center under the umbrella of the community health clinic in which the program is based. Vocational training forms the centerpiece; youths spend two or more days each week involved in hands-on job skills training. Youths begin with a set of job readiness and basic skill building activities, moving through a series of stages to employment in the community. Youths also participate one or two days per week in training modules targeting areas such as social skills, affect management, interpersonal problem solving, and drug and alcohol abuse.

One evening per week, youths and a parent (or involved adult) attend a group meeting. Participants and program staff share a meal together before breaking up into separate parent and youth groups. After youths and adults break into groups, youths engage in a series of activities designed to afford an opportunity to practice pro-social interactions while working on tasks centered around identity development. In an adjoining room, parents receive training in communication and behavior management.

Research

Currently, a pilot study with 25 youths is being conducted. This study is designed to (a) give information about the population being served, (b) explore the effectiveness of the enrollment and data collection procedures that have been implemented, and (c) give a preliminary indication of the effectiveness of the intervention in reaching desired outcomes. This pilot study will also guide the preparation of a proposal for a larger, outcome-based evaluation.

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California's System of Care Model for Reducing Juvenile Crime: Riverside County's Successful Interagency Program

Authors

Introduction Method Results Discussion References

Introduction

Riverside County's interagency program combines mental health, educational, and probation services in an effort to reduce juvenile recidivism. The program provides interagency services at three therapeutic high schools (12th Street, Perris, and Indio Community Schools) and one juvenile facility (Van Horn Youth Center) with the goal of keeping minors at home, and thereby reducing recidivism by keeping them out of restrictive facilities (e.g., group homes, juvenile hall, California Youth Authority).

Riverside County's interagency services began in FY 1989-90 under Assembly Bill 377 (AB 377) as part of the California System of Care (SOC) model first developed in Ventura County in FY 1984-85. After six years of AB 377 implementation (FY 1989-90 through FY 1994-95), Riverside County has served a total of 1,507 juvenile wards at the interagency community schools and juvenile facility. The sites currently are serving about 300 juvenile wards in FY 1995-96.

As a requirement of AB 377, the Riverside County Mental Health Department annually evaluates the effectiveness of interagency services in reducing recidivism among juvenile court wards. Previous evaluation found that the number of felony and misdemeanor offenses significantly decreased for wards one year after AB 377 services compared to their criminal activity the year before such services (within program outcomes). The number of felony offenses also declined compared with comparison group samples (between group samples).

Riverside County's interagency program for juvenile offenders is representative of the System of Care model being implemented in 19 other California counties. The goal of the state's Department of Mental Health is to establish System of Care programs in all 56 California counties and thereby replicate statewide the positive recidivism findings that have been reported in Riverside County.

After six years of interagency cooperation between the County Office of Education, the County Department of Probation, and the County Department of Mental Health, Riverside County reports two key outcomes with implications for reducing juvenile crime in California's counties:

- The total number of felony and misdemeanor offenses significantly decreases for juveniles one year after attending an interagency school/facility compared to their criminal activity the year before being assigned to program (within program outcomes).
- Juveniles are rearrested less often for felony and misdemeanor offenses one year after attending an interagency school/ facility compared with youths who attend non-therapeutic, non-interagency sites (between program outcomes).

Method

A pre-treatment and post-treatment design was used to evaluate the effectiveness of interagency programs in reducing juvenile recidivism. Juvenile recidivism was measured one year before receiving AB 377 services and one year after receiving such services. Four studies (FY 1990-91, FY 1991-92, FY 1992-93, and FY 1993-94) were conducted that employed the one year pre-treatment and one year post-treatment design. A fifth study was conducted (FY 1994-95) that employed a two-year pre-treatment and two-year post-treatment design. Comparison groups were used for the 1990-91, 1992-93, and 1993-94 studies to establish a non-treatment recidivism baseline.

The Riverside County Office of Education, the County Department of Probation, and the County Department of Mental Health provided collaborative educational, probational, and therapeutic services to wards at the interagency high schools and juvenile facility. Wards at the comparison sites received joint educational and probational services, but did not receive mental health services.

Sites

Samples were selected from four interagency sites (Van Horn Youth Center, 12th Street Community School, Perris Community School, and Indio Community School). Samples were also selected from two pre-AB 377 sites (Van Horn and Perris) and from a non-AB 377 community school (Jurupa) to serve as comparison groups. Juvenile wards who were discharged from the four AB 377 sites and who had at least two weeks of interagency services were randomly selected for inclusion in the studies. For the comparison group samples, juvenile wards who were discharged from Jurupa or a pre-AB 377 program and had attended that school for at least two weeks were randomly selected for the school for at least two weeks were randomly selected for the studies. Altogether, 239 wards receiving AB 377 services were randomly selected for the five recidivism studies; 71 wards were selected from the comparison groups.

Arrest and disposition records were examined for juvenile wards in the four interagency samples and the comparison group samples. These records were collected from official court and probation department documents. The number of sustained offenses by wards (i.e., felonies, misdemeanors, and probation violations) before entry into an AB 377 interagency program was compared with the number of sustained offenses after their exit from the program. The same information was collected for the pre-AB 377 and non-AB 377 comparison groups.

Analysis

Both inferential and descriptive statistical were used to analyze recidivism outcomes. Paired t-tests and t-tests for independent samples were used to measure recidivism before and after interagency intervention. The data is currently also being reanalyzed using a 2 x 2 (Condition x Time) repeated measures analysis of variance (ANOVA). In addition, the effect sizes (also known as program or clinical effectiveness) corresponding to the inferential statistics were also reported. Two types of significance testing were thus reported: statistical significance and clinical significance (effect size).

An effect size is a statistical measure of program effectiveness that compares the degree of a program's effectiveness against a baseline or comparison group. A program can have a result that is simultaneously statistically non-significant and clinically significant. One may infer statistical significance from a clinically significant outcome; that is, a clinically significant outcome denotes a statistically significant outcome (Cohen, 1988; Thompson, 1993).

Results

Overall, findings suggest that AB 377 has been effective in reducing the number of felony offenses committed by wards. The number of felony offenses committed by wards at Van Horn and the three community schools significantly declined one year after AB 377 services compared to felony offenses committed one year before such services

($t = 5.40$, $df = 121$, $p < .001$). The number of felony offenses also declined compared to the comparison group samples. When compared to a pre-treatment comparison sample, the number of felony offenses committed by wards significantly declined at Van Horn one year after AB 377 services compared to felony offenses committed one year before such services ($t = 2.03$, $df = 59$, $p < .05$; see Figure 1). The decline of felonies from pre-treatment to post-treatment approached significance for wards at the three community approached significance for wards at the three community schools (t = 1.72, df = 203, p < .09) when compared with the non-AB 377 samples (see Figure 2).

The differences in felony offenses between the AB 377 sites and the comparison samples were all clinically significant. Based upon effect size analyses, 44% of the wards from the community schools were likely to commit a felony after AB 377 services compared with 56% of minors from the comparison groups; 37% of the wards from Van Horn were likely to commit a felony after services compared with 63% of wards from the comparison group. Employing a measure of effectiveness (Rosenthal, 1984; Rosenthal & Rubin, 1982), the AB 377 interagency program was 12% more effective in reducing felonies at the community schools than were the comparison programs; it was also 26% more effective at reducing felonies at Van Horn than the comparison group.

The effect size difference for the community school wards relative to the comparison group was .25 standard deviations, felony recidivism was thus reduced by a quarter standard deviation. The effect size difference for the Van Horn wards relative to the comparison group was .53 standard deviations, felony recidivism was thus reduced by more than half a standard deviation. Employing Cohen's (1988) measure of effect size rubric, the community school and Van Horn effect sizes represent small and medium effect sizes, respectively.

The therapeutic interagency programs were therefore (clinically) effective in reducing felony recidivism. The (clinical) effectiveness of the AB 377 community schools and Van Horn in reducing recidivism compares favorably with the success rates (effect sizes) reported in 200 recidivism studies reviewed by Lipsey & Wilson (1992) that show that between 43% to 45% of juvenile wards were likely to reoffend after intervention services compared to 54% to 57% of minors in programs without intervention services.

The fifth study that employed a two-year post-treatment design showed a decline over time in juvenile recidivism (see Figure 3) based on descriptive statistics (inferential statistics have not yet been conducted). This study also showed that juveniles who previously reoffended were likely to reoffend within the first three to six months after receiving interagency System of Care services (see Figure 4). Wards who did not reoffend one year after services were likely not to reoffend during the second year after services.

Discussion

California's System of Care as implemented in Riverside County is helping deter juveniles from committing additional crimes. Riverside County's interagency program for juvenile offenders is similar to a model that is also in place in 19 other California counties. San Mateo, Santa Cruz, and Ventura counties have also reported that juvenile wards commit fewer felonies and misdemeanor crimes one year after their AB 377 System of Care services compared to their criminal activity the year before such services.

The goal of California's Department of Mental Health is to establish system of care programs in all 56 counties and thereby replicate positive recidivism findings statewide. The positive recidivism outcomes in Riverside County show that the interagency System of Care approach offers other counties in California an effective model for reducing juvenile criminal activity. John Ryan, Riverside County Director of Mental Health and past President of the California Mental Health Director's Association, stresses that "We have shown through research the effectiveness of our collaborative work with juvenile offenders. We have also shown that an interagency approach is more effective when working with juvenile offenders than either mental health or probation trying to work alone."

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The Relationship of School-Based Services to Mental Health Networks

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Introduction

Reforms including integration of children's mental health services have emerged in a variety of regions, communities, and institutions. Consequently, psychologists and other mental health professionals are increasingly interested in working with schools to provide better, integrated services (Carlson, Tharinger, Bricklin, DeMers, & Paavola, 1996; Paavola et al., 1996). To support these collaborations, it is important that child services professionals understand how schools relate to a network of care for children's mental health services.

This summary examines the role of schools in integrated service delivery using data from a project in South Carolina that provides services to children with severe emotional disturbance (SED). South Carolina presents an interesting case of state child service systems reform; beginning in 1989, it was one of the first states to develop Medicaid services utilizing local education agencies as medical providers. The Medicaid office and the Department of Education identified potentially reimbursable services, including psychological services. In July, 1995, the Medicaid agency was renamed the Department of Health and Human Services, and supported services for eligible children with a disability through an Individual Education Plan (IEP; Cantrell, 1996). These services were provided in the school building, using a strategy sometimes known as "push-in" integrated therapy. This contrasts with a strategy of "pull-out" clinical services, in which children needing services are removed from the classroom and school.

The involvement of schools in a network of care for children with SED is important for several reasons. Schools are potentially effective health delivery systems for children because they are stable, universal, and cost-effective (Carlson et al., 1996). To some extent, public schools have served to integrate children's social services since their inception (Fagin, 1992). Schools may work with families to ensure that their services are appropriate to both the family and the school's administration. In exceptional or special student education, an IEP that integrates services and service providers is essential to child health and family involvement in education (Duchnowski, Kutash, & Knitzer, 1995). Along with inpatient or residential services and mental health counseling, schools are a major axis of care and expense over time for children with emotional or behavioral problems (Epstein & Quinn, 1996).

Additionally, children with serious emotional or behavioral disorders often receive care from multiple service providers. Responsibility for care and health outcomes is shared, and the degree to which this shared responsibility is coordinated can be improved through system interventions (England & Cole, 1995; Friedman, 1996). Under these conditions, system coordination appears to be critical (Johnsen, Morrissey, & Calloway, in press). The degree of change in integration and coordination of child services may be measured using network analysis (Morrissey, 1992). In evaluations of service integration programs in upstate New York and western North Carolina, social network analysis demonstrated that service enhancements such as co-locating services and expanded case management, created greater systems integration (Morrissey, Johnsen, & Calloway, 1994).

In the context of a national mandate to establish systems of care for children (Stroul & Friedman, 1986), comprehensive care and full-service school models have become prominent (Dryfoos, 1994; Roberts, 1994). In terms of actual service use, research suggests that schools already provide a large proportion of mental health services for children and adolescents. In western North Carolina, the Great Smoky Mountain Study (GSMS) focused on representative 9-13 year olds attending public schools. In the GSMS, only 40% of children with SED received services. Of children with SED who received services, only half received them in the mental health sector (Burns et al., 1995). Mental health services in the education sector were reported for 71.5% of children with SED (vs. 41.5% who reported receiving services from community mental health providers). Earlier studies support the importance of school-based mental health services, identifying teachers as the professional group that most often serves children with mental health problems (Cohen et al., 1991; Offer, Howard, Schonert, & Ostrov, 1991).

Method

How are schools involved in networks of care for children with SED? This study examined organizations participating in a mental health services demonstration sponsored by the federal Center for Mental Health Services (CMHS) and administered by a Community Mental Health Center in an urban area of South Carolina. A rural comparison region served three nearby counties. A systems-level assessments was designed to measure differences in development and coordination among service organizations in the demonstration site (n = 61) and its comparison community (n = 39). In the urban demonstration site, organizations serving children with SED were coordinated through a system of care model and featured multi-systemic therapy, an ecological treatment model (Henggeler & Bourdin, 1990; Henggeler et al., 1994). Baseline data were collected between December, 1994 and May, 1995. The sample of organizations in this study was unique because the sample was carefully designed to include a range of schools in the region. The project was funded for 5 years, and services began in March, 1994.

This study used an inter-organizational network survey based on Van de Ven and Ferry's "Organizational Assessment Instrument" which has been tested for validity and reliability (Morrissey, Johnsen, & Calloway, 1994; Van de Ven & Ferry, 1980). Researchers gathered responses from over 90% of 117 services identified in the two counties. Selected services were those which performed a CASSP function (Stroul & Friedman, 1986), were identified as a key agency, and/or were used by children with SED. The survey instrument included detailed indicators of client referral patterns and information exchange relationships among child serving agencies in the region.

The inter-organizational network of referral and communication among services for children with SED was summarized by indicators of social network structure, including connectedness, density, and centralization (Wasserman & Faust, 1994). Network analysis techniques provided the number and density of referral and communication ties to and from particular service providers. Analysis at the system level was complemented by analysis of schools in the network, including a comparison of those urban schools with and without in-school therapeutic intervention.

Results

The network of service providers was moderately integrated in both the urban and rural regions, and more centralized in the rural region. The client referral patterns among 61 organizations in the urban service delivery network were more dense (18% vs. 13%) and less centralized (.26 vs. .43) than the 39-organization rural network (see Table 1). Density is a measure of the proportion of possible ties which

Density is a measure of the proportion of possible ties which are present, expressed as a proportion of non-zero cells in a n-by-n organizational matrix. Similarly, the information exchange patterns were more dense in the urban region (.23 vs. .18) and less centralized than those found in the rural area. This could have been due to a smaller student and client population in the rural network, requiring fewer relationships between services and allowing greater centralization of services. These findings also may have been related to greater integration in the urban region as a result of the early effects of the CMHS project.

Table 2 reports a Z-test for the difference between two proportions to compare the density of system ties and the connectivity of school ties for rural and urban systems. The urban density measures for referrals and information exchanges were significantly higher than rural measures ($p < .01$).

The "connectedness" of schools (the proportion of possible ties to or from schools to other system respondents) refers to the network density of relations involving particular schools but excluding the school district office.

Although the service system as a whole was more dense, urban region schools show a significantly lower degree of connectedness in terms of the proportion of services to which they send clients ($Z = 2.4$). In general, there were no significant differences in connectedness; schools exchanged clients and information with relatively few other services (one in ten, or less). The low connectedness measures were partially due to the fact that the school district office, which was central and highly connected with other services, was excluded from the analysis of school ties.

In order to examine the potential benefit of the demonstration, Table 3 compares urban schools with and without school-based counselors (SBCs). Proportionately, the urban system schools with SBCs sent clients to more than twice as many service providers as the schools without SBCs ($Z = 2.66$). Likewise, the schools with SBCs sent communications, proportionately, to almost twice as many other providers. This suggests that schools with SBCs may actively initiate relations with other services to a greater extent than those without SBCs. Most of the schools in the sample were elementary level, suggesting that urban region SBCs were most active in advocating for services for younger children with SED.

Discussion

Schools are important service providers for children with SED, but they are not always highly integrated within a larger system of child mental health services. This summary described schools in two districts that were somewhat isolated from other providers in the local service system. School-based mental health counselors, however, played an important role in bringing schools into the system of care, primarily through increased client referrals. The presence of primarily through increased client referrals. The presence of school-based mental health counselors was associated with more than twice as many client referrals and almost twice as many information exchanges from schools. Although the survey was conducted at an early point in a demonstration project, it suggests that school-based mental health counselors may increase the integration of schools with the larger system of care, building bridges of referral and information to better serve the needs of children.

Since the results reflect less than a year of intervention in one state, and since the comparisons were across services rather than over time, the full impact of school-based counselors cannot be fully assessed using these data. In addition, these results are limited to a single demonstration in a particular area and context. Future research should examine the role of schools in different regional contexts, and ensure that schools are included as respondents in surveys regarding the provision of mental health services for children. Families and counselors should be partners in both health and education, meeting needs of children in their most familiar environments. Bringing services into schools, in addition to referring children out to services, may improve both health and education, in addition to supporting the CASSP goal of providing services in the least restrictive environment.

As interventions are implemented, social network analysis can be used to measure the impact of the integration process and to evaluate the degree to which new service models help schools cooperate within a system of care. In addition, there is some evidence that school level (e.g., elementary vs. high school) is related to the degree of service integration, so developmental issues should be considered. Relationships between schools and other SED service providers may be identified and promoted when they serve the interests of children.

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Chapter 7

Crisis Services & Residential Care

The 9th Annual Research Conference Proceedings, A System of Care for Children's Mental Health: Expanding the Research Base (February 26 - 28, 1996).

Child Outcomes of a Field Experiment on Intensive In-Home Interventions for Children in Psychiatric Crisis

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Introduction

Each year many children and their families present at emergency service settings seeking help for psychiatric crises. Little is known about the treatment that these children receive or the effectiveness of the treatment provided. If a child is assessed as not in need of immediate inpatient care, one option is the provision of intensive in-home services. These interventions, often modeled on the Homebuilders program developed for a child welfare population (Fraser, Pecora, & Haapala, 1991), have not been systematically evaluated to assess their outcomes when used for a mental health population. The purpose of this study was to assess the combined child, family, and system outcomes of three in-home psychiatric emergency programs all located in the same urban community.

In 1987, the New York State Office of Mental Health established Home-Based Crisis Intervention (HBCI) as an intensive in-home service option for families with a child in psychiatric crisis. HBCI is modeled on the Homebuilders program developed in Tacoma, Washington (Kenny, Madsen, Flemming, & Haapala, 1977). This program provides short-term intensive services to families with children who are at risk of out-of-home placement. Counselors work with two families at any time with a goal of preventing psychiatric hospitalization or out-of-home placement. The intervention focuses on family strengths and needs using a multifaceted approach including skills building, counseling, and the provision of concrete services.

A research demonstration grant (Evans, 1992) from the National Institute of Mental Health (1R18MH50357) and the Center for Mental Health Services (5HD5SM50357) allowed us to develop an enhanced HBCI program (HBCI+), based in part on lessons learned in prior research (Evans, et al., 1994). The study site is located in the Bronx, New York, a densely populated borough of New York City characterized by cultural diversity and intense poverty. In order to answer questions about the effectiveness of these two models, we further modified a generic case management program to create Crisis Case Management (CCM), an intensive, short-term intervention whose purpose was to do rapid assessment of child and family needs and to link to needed services. The development of CCM was to answer the question about whether a linkage and advocacy model of in-home services results in the same outcomes as in-home programs focused on skill building and treatment.

Details on all three interventions, which are provided in-home for 4 to 6 weeks, are available elsewhere (Evans, Boothroyd, & Armstrong, 1996). In this presentation, we will concentrate on aggregate data across the three program types.

Method

Children were referred to the study following evaluation by a child and adolescent team at two psychiatric emergency rooms. Children referred for consideration were assessed as being at risk of either hospitalization or out-of-home placement without immediate intensive intervention. If a child met the study criteria and the family and child were willing to participate, the family was randomly assigned to one of the three interventions. Criteria for inclusion were that the child be (a) between the ages of 5 and 17; (b) living in the Bronx with a natural, foster or adoptive family; and (c) experiencing a psychiatric crisis requiring immediate intensive intervention, hospitalization, or placement in another restrictive setting. Moreover, the child's family had to be willing to receive services, and the environment in which the child lived had to be safe. Data on multiple aspects of child and family status and functioning were collected on admission to the study, at discharge from the intervention (4&endash;6 weeks), and six months following discharge. Data reported in this manuscript are preliminary and are based on the first 221 children admitted to the study. Other presentations (Evans, Boothroyd, & Kuppinger, 1997; Boothroyd, Kuppinger, & Evans, 1997) focus on additional aspects of this study.

Results

To understand the characteristics of children referred to the study in the context of all children presenting at the emergency rooms, clinicians were asked to assess the overall dangerousness of each child's condition. The assessment device that was utilized was the Child and Adolescent Mental Health Assessment of Imminent Danger (Gutterman & Levine, 1992). On a five-point scale, ranging from none (0) to severe (4), children referred for hospitalization (N = 208) had a mean score of 2.64; those referred for in-home services (N = 179) had a mean score of 1.85; and those referred to other community-based services (N = 620) had a mean score of 1.14. All between-group

(N = 620) had a mean score of 1.14. All between-group differences are statistically significant at p = .05. There was also a perfect order effect between the seriousness of a child's condition, the child's assessed ability to participate in services, and the ability of the caretaker to provide a supportive environment and participate in services with the treatment environment selected by the clinicians (i.e., children identified as having the most severe clinical statuses, who were least able to participate in their own care and whose caregivers were least able to provide care, were more likely to be hospitalized). Children at the opposite extremes on these variables, however, were most likely to be referred for outpatient services. Children who scored as intermediate on the risk variables were those most often referred to the in-home intervention.

Additional characteristics of the 221 children served by the project in the three intensive, in-home interventions appear in Table 1. Particularly remarkable is the proportion of children with clinical diagnoses of psychotic disorders and the low incomes of their families, most of which are below the poverty line (see Evans, Boothroyd & Kuppinger, 1997).

One of the primary proximal outcomes of interest in this study is self-esteem. The Piers-Harris Children's Self-Concept Scale (Piers, 1984) was used to measure this variable. Based on the first 152 children who completed the three intensive interventions, the data show that the mean score at intake was 50.5, which was below that of a normative group of children with emotional disturbances. The data also show that the mean score at discharge had increased to 53.7, which is statistically significant at the .05 level. Figure 1 shows the subscale gains from entry to discharge. Children showed significant gains, ranging from .001 to .05, on all subscales except Popularity. A smaller sample (N = 98) of children with data from all three data collection points shows that the gains made between intake and discharge were retained at six months.

Child satisfaction with services is assessed at discharge from each of the in-home interventions. Children (N = 158) show high levels of satisfaction with nearly all aspects of their care. The only items with more than 20% of the children expressing dissatisfaction or a lack of clarity were: (a) knowing why the counselor or case manager came to see them initially; (b) being satisfied with the counselor or case manager getting them other services; and (c) being terminated from service before they were ready.

In regard to the disposition of children, using the most complete data available at this time, which includes the 221 children reported here and an additional 75 children recently admitted, 296 children and families have been referred to the study. Of these, 233 completed the intervention, while 38 were considered early terminations (i.e., they did not complete the entire intervention). Twenty-five of the children required hospitalization at some time during the intervention. The most usual placement for children at both admission and discharge (88.9%) was living with their admission and discharge (88.9%) was living with their family or other relatives.

Discussion

The data presented reflect only a small sample of that collected during the research demonstration, which is still in progress. Based on these data, some questions have been raised regarding whether in-home crisis intervention programs are serving as a hospital diversion program in New York, as had once been expected. Clinicians, exercising their judgment, differentiate among children who are referred for hospitalization, for in-home services, or for other community-based services. Despite the increased capacity the grant resources have brought to serve children and families in their homes, hospitalization rates have not changed significantly at the two participating hospitals (about 20%). Rather than preventing hospitalization, in-home services may represent another community-based option for children whose safety and clinical needs are not as acute as children judged as requiring hospitalization. It has not been determined what the hospitalization rates would have been at these hospitals without the introduction of these additional resources. Also, initial discussions with other researchers working in this area of study indicate that the children seen in emergency settings in the Bronx have more serious problems than children assessed in settings elsewhere in the country (Gutterman, Evans, Levine, Boothroyd, & Drennan, 1996). Additional analyses are needed to answer the hospital diversion question.

Children enrolled in in-home services gained in self-esteem, and these gains were maintained over the follow-up period. Also, most were able to avoid hospitalization during the initial period of service. Avoidance of hospitalization assumes particular importance when considering the following points: (a) that many of these children appeared to be in crisis at the time of their presentation; (b) a significant minority were diagnosed with psychotic disorders and/or had been hospitalized previously; and (c) the overall dangerousness of the child's condition, on average, was determined to be moderate.

Since this study is still in progress, analyses have not yet been performed to examine the differential outcomes that may be associated with the three program models. There is support, however, for the assertion that children in psychiatric crisis and their families can receive effective, intensive supportive care safely in the community, and that gains in self-esteem persist for at least six months following discharge.

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Preliminary Family Outcomes of a Field Experiment on Intensive In-Home Interventions for Children in Psychiatric Crisis

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Introduction

Every parent, every service provider, and every researcher working in the field of children's mental health shares the common concern that our service system be able to respond quickly and effectively to children who are experiencing a psychiatric crisis. Even as the range of community-based service options has expanded in recent years, and even though there has been an increased commitment to prevent unnecessary hospitalization, there is little research available to help us understand which models of crisis intervention are effective, for whom, and under what circumstances.

In 1987, New York State initiated Home-Based Crisis Intervention (HBCI), modeled on the Homebuilders program developed in Tacoma, Washington (Kinney, Madsen, Fleming, & Haapala, 1977). HBCI provides short-term, intensive, in-home services to families whose children are at risk of out-of-home placement because they are experiencing a psychiatric crisis. Beginning in 1992 with a research and demonstration grant from the National Institute of Mental Health (IR18MHS0357) and the Center for Mental Health Services (SHDSSM50357), a three-year field experiment was conducted to evaluate the effectiveness of HBCI and two additional short-term crisis intervention models, Enhanced Home-Based Crisis Intervention (HBCI+) and Crisis Case Management (CCM). The purpose of the study was to evaluate the family, child, provider, and system outcomes of these three interventions. The study took place in the Bronx, New York, to assess the impact of these interventions with a population that was ethnically diverse and under extreme economic stress.

Each program offered in-home services for four to six weeks, with small caseloads ranging from two to eight families per worker. Workers had flexible schedules and were available by beeper, 24 hours a day, seven days a week. Two of the programs, HBCI and HBCI+, followed the Homebuilders model, which employs a cognitive behavioral approach for defusing crises and teaching skills while linking families to a variety of ongoing services. HBCI+ has the added resources of in-home and out-of-home respite care, a parent advocate, a parent support group, flexible service dollars, and additional training on cultural issues as well as on the impact of violence on children. The third program, CCM, is a short-term adaptation of an intensive case management (ICM) program. Workers in CCM carry four crisis cases and four longer-term ICM cases. The focus in CCM is on assessing need, providing concrete services, and linking the client to ongoing services. Families enrolled in CCM also have access to respite care services. More information about the three interventions can be found elsewhere (Evans, Boothroyd, & Armstrong, 1996).

This summary describes the characteristics of the families who were enrolled in the study and reports preliminary findings (aggregated across all three interventions) on family outcomes as measured by: (a) the Family Adaptability and Cohesion Evaluation Scales II (FACES II: Olson, Portner, & Bell, 1982); (b) the Inventory of Socially Supportive Behaviors (ISSB: Barrera & Ainlay, 1983); (c) the Parent/Caregiver Self-Efficacy Scale; and (d) the Parent/Caregiver Satisfaction Survey. The latter two measures were developed by researchers in the Bureau of Evaluation and Services Research of the New York State Office of Mental Health. Another presentation in these proceedings (Evans, Boothroyd, & Holohean, 1996) focuses on child outcomes.

Method

From November, 1993 through December, 1995, all children who presented at two emergency rooms were screened for eligibility for the study. To be eligible, children had to be between 5 and 17 years of age. Children also had to live in the Bronx in a natural, adoptive or foster home with a caregiver who was willing to participate, and the child had to be able to remain at home safely with intensive services even though they had significant mental health needs. The emergency room psychiatrists and psychiatric social workers conducted the assessments and were instructed to refer only children who would likely be hospitalized in the absence of crisis intervention services.

All eligible children whose parents consented to participate were randomly assigned to one of the three programs. Data were collected at intake, discharge from the intervention, and six months following discharge. The data reported here are preliminary. More in-depth analysis will be conducted when data collection is complete in the fall of 1996. In all, 296 children were referred to the study, 233 were discharged, 38 withdrew from the study prior to discharge, and 25 were hospitalized during the intervention. Descriptive data and satisfaction data are presented for the approximately 221 families discharged as of January 1996. Data concerning changes from intake to follow-up are presented for approximately 115 families for whom six month follow-up data were available.

Results

The families enrolled in this project were representative of the demographics of the Bronx. Sixty-three percent were Hispanic, and 26% were African American. Eighty percent of the families had annual incomes of less than $20,000, with 53% below $10,000. Only 20% of the primary caretakers were employed. Seventy-two percent of the caretakers were single parents. Fifty-five percent of the primary caregivers had completed high school.

The average age of enrolled children was about 11.5 years, with slightly more children (56%) than adolescents. Disruptive behavior (29%) and adjustment disorder (18%) diagnoses were the most common. Seventy-one percent of the children had at least one functional impairment, and 94% were judged to have behaviors that endangered themselves or others. While the majority of children were in special education (53%), and many had received prior mental health treatment (42%), relatively few had been previously hospitalized (11%).

On FACES II, statistically significant gains were found in both cohesion and adaptability from intake to discharge. The six month follow-up assessments indicate some erosion in these gains, which is statistically significant for the cohesion subscale (see Figure 1).

cohesion subscale (see Figure 1).

A preliminary analysis was conducted to determine if there were any child or family characteristics that might distinguish between families who experienced more positive versus more negative outcomes as measured by FACES II. None of 21 characteristics examined (e.g. age, gender, diagnosis, family composition, maternal education level) were found to be significant.

The Parent/Caregiver Self-Efficacy Scale assesses how comfortable parents feel with their parenting skills and ability to care for their child. Intake to follow-up gains in caregiver self-efficacy are presented for four of the domains assessed (i.e., behavioral management skills, dealing with school-related issues, ability to advocate, and providing emotional support). Of these, only the gains in behavior management and emotional support were statistically significant. There was a statistically significant decline from intake to follow-up in caregivers' feelings of being able to effectively meet the basic needs of their children (see Figure 2).

The ISSB indicated an extremely low level of perceived informal support among all enrolled families (average score = 86 out of a possible score of 200). Preliminary findings suggest that the interventions have little impact here, and that there is actually a decline from discharge to follow-up, which is statistically significant (see Figure 3).

Each child and primary caregiver is asked at discharge to complete a satisfaction questionnaire. Caregivers were particularly satisfied with the counselor or case manager's advice, cultural understanding, and handling of personal issues. Similarly, caregivers were very satisfied with the help they received, their access to the counselor or case manager, and the extent to which their counselor or case manager was well-informed (see Figure 4).

There was a little less satisfaction with the counselor's or case manager's ability to link the family with other services, the quality of skills teaching, the time it took the worker to contact them upon referral from the emergency room, and the overall frequency of contact. Nevertheless, even on these items, the percentage of caregivers who reported that they were very satisfied never fell below 80%.

Discussion

The results presented in this paper are at first glance a small subset of the data collected during this field study which is still in progress. While the children are the primary subjects of the study, our examination includes an in-depth look at the families who care for and support each of these young persons on a day-to-day basis.

In this preliminary analysis of change on three family/caregiver measures, we have aggregated results across all three interventions. Given the focus of at least two across all three interventions. Given the focus of at least two of the interventions on family problem solving and communication, it is not surprising to see gains in both dimensions of FACES II from intake to discharge. The erosion in these gains from discharge to follow-up may be related to the fact that, while some families were referred to other community-based services upon discharge, few of these services were as intensive, and most did not focus specifically on maintaining these gains.

As suggested by the extremely low baseline scores on the ISSB, the families enrolled in these interventions are not only grappling with significant stress, but the majority are doing so in isolation. None of the interventions focused specifically on broadening family's networks of support, and in the six weeks from intake to discharge, no significant change was measured. A sense of loss following discharge from an intensive intervention is one possible explanation for the significant decline from intake to follow-up. In future analyses, we will look at this issue more closely to determine if there are differences among the three interventions or differences based on the degree to which families participated in family support and recreational activities. We will also look at whether there is any correlation between the perceived level of informal support and other outcomes.

Clearly, there are many more analyses to be conducted to explore the myriad questions embedded in this study. In designing an analytic plan, we will take a variety of approaches that might include the use of composite measures, the weighting of certain measures based on a rationale associated with the intent of the intervention, and other strategies. While preliminary findings support the hypotheses that children in psychiatric crisis can remain safely at home with intensive in-home services, future analyses will hopefully enable us to comment in more detail about which interventions work best for which children and their families and why.

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Addressing Children's Exposure to Violence in a Short-Term Crisis Intervention Program

Authors

Introduction Collection of Violence Data Findings References

Introduction

The Bronx is a community plagued by chronic violence. In 1994 Bronx county was ranked first in New York State counties for violent crimes with 2.316 violent crimes per 100,000 people. In 1994 the Bronx had the highest murder rate of any New York State county (33/100,000) representing 20% of all the state's murder arrests. A story on the front page of the Bronx Daily News (Monday, September 11, 1995) indicated that only two Bronx elementary schools reported no weapons possession cases during the year and only one school reported no serious assaults on students at school. Another story that same day reported the confession of four Bronx teenagers arrested for the murder of a 19 year-old mother and a bystander at a local playground. The motive&emdash;a dispute stemming from a softball game two days earlier. While it is difficult to specifically quantify the impact of community violence, the behavioral consequences of children living in chronically violent communities has been widely documented and include difficulty concentrating, memory impairment, increased anxiety, aggressiveness, and uncaring behavior (Garbarino, 1995).

During the past four years the NYS Office of Mental Health has been conducting a study in the Bronx, NY comparing the effectiveness of three models of intensive in-home, emergency services as an alternative to hospitalization for children and adolescents experiencing psychiatric crisis. Two hundred and ninety-six eligible children were randomly assigned to one of the three models and received four to six weeks of services. While the support services available to families differed across the three program models (e.g., respite care, support groups, parent advocacy, etc.), each model provided families with intensive services (i.e., small caseload sizes ranging from 2 to 8 cases) that were available 24 hours a day, seven days a week and delivered in a family's home.

This summary (a) summarizes the data collected from some of the children and adolescents in this study regarding their exposure to violence and its effect; (b) briefly describes the training, technical assistance, and case supervision counselors received focused on violence issues; (c) summarizes selected strategies that workers use as a result of these efforts to address the effect of violence; and (d) presents a case study demonstrating how violence was interwoven in the life of one child and her family.

Collection of Violence Data

Respondents - Children surveyed were among those children referred from a psychiatric emergency room to receive approximately four to six weeks of intensive in-home services as a result of a recent psychiatric emergency. The children ranged in age from 5 to 18, were living at home with their biological, foster, or adoptive families, and had experienced a psychiatric crisis that would have required hospitalization without the availability of intensive in-home services. As of January 1996, 36 children had been interviewed about their exposure to violence.

The ten counselors providing the intensive in-home services were interviewed in order to retrospectively obtain individual case information for the purpose of constructing a series of case studies.

Measures - During the regularly scheduled six month follow-up interview the children who received intensive in-home services were asked a series of questions regarding: (a) their exposure to violence, (b) how safe they felt in various settings, and (c) their knowledge of other children carrying weapons.

A semi-structured interview protocol was designed and used with counselors at the end of the study. The protocol focused on specific aspects of individual cases they had handled during the study with particular emphasis on violence issues.

Analysis - Descriptive statistics were used to report children's responses to the questions on violence. Case study methodologies were used to synthesize and summarize the counselor interviews.

Findings from Interviews with Children

To what extent are children exposed to violence?

Figure 1 summarizes the responses of the children to several questions regarding their personal experience with various types of violence. As shown in this figure, 87% percent of the children surveyed reported having witnessed someone being "beaten up" while 34% reported that they had been beaten up. Over one quarter of the children (26%) indicated beaten up. Over one quarter of the children (26%) indicated knowing someone who was robbed while nearly one fifth of the children (19%) indicated having been robbed. Almost one quarter of the children (23%) knew of someone who had been stabbed while 3% reported having been stabbed themselves. Although none of the children interviewed had been shot at, nearly a third of the children (31%) knew someone who was shot at.

Do the children have friends who carry weapons?

Children were asked if they had friends who carried weapons. Approximately 40% of the children interviewed reported having friends who carry a knife. Nearly a quarter of the children (24%) reported having friends who carried a gun while 30% of the children had friends who carried some other type of weapons. The most popular among other weapons were razor blades and box cutters.

Where and with whom do children feel safe?

The children were asked several questions about how safe they felt in various places alone or with adults. These responses are summarized in Figure 2. As is shown in this figure, half of the children (50%) reported feeling unsafe on the streets by themselves. Forty percent felt unsafe at the movies, 29% unsafe at school, and 19% unsafe at home. Across all settings, children reported feeling safer when accompanied by an adult; however, 20% still felt unsafe on the streets even when they were with an adult.

Enhancing Counselors' & Case Managers' Abilities to Respond to Violence

Three activities were undertaken in an effort to enhance counselors' ability to respond to issues related to violence while working with children and their families. These activities included the provision of specialized training, technical assistance, and case supervision focused on violence issues.

Dr. Marsha Lewis from Edge Associates in Pittsburgh, PA conducted a two day training program entitled "Family Systems Theory as a Framework for Understanding Family Violence." This purpose of this training was to provide counselors and case managers with a conceptual framework grounded in family systems theory to better understand the dynamics of domestic violence and how to implement practical intervention strategies.

Dr. James Garbarino, Director of the Family Life Development Center at Cornell University, provided counselors with four days of technical assistance and case review. His focus with the counselors was on the negative consequences that trauma exerts on children and the development of strategies for dealing with these consequences.

Ms. Katherine Gordy-Levine, Coordinator of the Enhanced Home-Based Crisis Intervention program, provided case supervision for her staff on violence issues using a conceptual framework she developed that included three intervention levels: (a) providing support, which includes meeting concrete needs and addressing immediate safety issues as well as listening and affirming; (b) enhancing cognitive strategies through teaching skills (e.g., fair fighting, relaxation techniques) and coping strategies (e.g., developing planned responses to specific situations); and (c) the use of environmental modifications (e.g., removal of a family member, moving to a new apartment) or external options (e.g., medication).

Selected Strategies Counselors and Case Managers Use to Respond to Violence

As a result of the activities described above, the counselors employed a variety of strategies in response to the ongoing presence of community and domestic violence as part of the intensive in-home services they provided. Early in the intervention they conducted a safety analysis of the home environment examining various aspects of the home ranging from the adequacy of the door locks to the presence of possible weapons or dangerous implements in the home. Flexible service dollars could be used to purchase new locks or make necessary safety repairs. Plans were implemented with families to reduce the risks of other potential dangers in the home. During the intervention they promoted future-oriented activities with the child and family such as gardening, taking care of pets, and schooling to respond to the hopelessness that typically accompanies living in a community plagued with violence. Counselors and case managers also promoted greater participation in face-to-face family activities such as playing games to replace solitary activities such as watching television. As a therapeutic response, they often had children develop written journals to help them deal with their exposure to trauma.

The Story of Susan and Her Family

Susan (a pseudonym) was a 15 year-old Jamaican female with no prior history of mental health treatment. A former boyfriend and his friends broke into her family's apartment, burglarized it, and sexually assaulted Susan and her mother. In her attempt to escape and get help, Susan jumped from a second floor window, breaking both of her legs. Out of fear and anger stemming from this assault, Susan's mother refused to bring her home from the hospital.

Susan and her family were referred for intensive in-home services. First, the counselor met the family prior to Susan being released from the hospital and helped facilitate an agreement between Susan and her family that would allow her to come home. Flexible service dollars were used to repair the window and fix the door locks. The counselor taught the family specific communication skills involving the use of "I statements" and "feeling statements" to improve communication among the family members and to reduce blaming. The counselor also explained the effects of trauma and taught them relaxation techniques to help them with the increased arousal they experienced in response to this event. The counselor helped the family plan fun activities together and referred them to victim services and a mental health clinic for ongoing support.

As a result of these efforts, Susan was able to remain at home with her family. According to the counselor, the number and quality of the interactions between Susan and her other family members also increased during the intervention. Finally, the family was linked to support services to continue to help them cope with the effects from the violent assault.

Summary and Discussion

In addition to the specific psychiatric needs of these children, for many, issues of violence have also been a persistent threat. Given this fact, the intervention provided to these children and their families has attempted to systematically address violence issues within the context of the provision of short-term intensive, in-home crisis services. Staff have received specialized training, technical assistance, and case supervision throughout the study in an effort to incorporate strategies that hopefully will begin to ameliorate some of the negative consequences associated with living in communities and households where violence is present.

The responses of the children interviewed indicate that many have witnessed or personally experienced violent acts. Many of the children report feeling unsafe when alone in their neighborhood, at school, and most disturbing, in their homes. While the presence of an adult helps promotes feelings of security for many children, for many others it does little to calm their fears. Their response&endash;carry a weapon and provide one's own protection.

While the primary goal of the services provided as part of this study is to abate an existing psychiatric crisis thereby avoiding hospitalization, the need to place emphasis on reducing the myriad of stressors that impact these children and families has become increasingly evident during this study. We cannot specifically document the degree to which the increased emphasis placed on incorporating strategies for dealing with violence in this study has resulted in improved outcomes for children and their families; nevertheless, we do know that for Susan, her mother, father, and brother, the impact of violence was central to their family's crisis, and that the counselor's strategies allowed Susan to remain at home, while helping the family cope with the lingering and dramatic effects of the violence inflicted upon them.

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Modeling Utilization of Child Residential Psychiatric Treatment

Authors

Introduction Method Results Discussion

Introduction

Much concern has been expressed about the high utilization rates of psychiatric hospitals, both public and private, for children and adolescents in our nation and in the State of Tennessee. These restrictive placements may not meet the needs of the child so placed, perhaps causing harm in some cases, and are so expensive that they deplete what are already scarce fiscal resources. The establishment of a continuum of mental health care that would offer a range of services has been the goal of the Tennessee Department of Mental Health for several years and was a focus of the Tennessee Children's Plan.

The Tennessee Children's Plan represents Tennessee's efforts to reorganize the delivery of services to children through a coordinated service system for children, youth, and families. The Children's Plan was phased in over the 18 month period between October, 1991 and April, 1993. Although state resources have been channeled into communities toward less restrictive care, residential services are still heavily used. In Tennessee, millions of state dollars flow both into the public and private service sectors under TennCare (the Medicaid waived managed care system for Tennessee) for inpatient psychiatric care. In addition, departmental funds have been used to pay for residential services not reimbursed by the TennCare or other third-party-payor systems.

This ongoing study was designed to provide some very basic information for filling some of the numerous gaps that exist in the knowledge base about the use of both inpatient and residential mental health care for children and adolescents in state care. This summary presents data from three aspects of the project: (a) the Baseline Survey, (b) Baseline - 1995 comparisons, and (c) patterns of placements leading to hospitalization.

Method

Sample

This study focused on children and youth, ages birth through 21 years, who were in the custody of the State of Tennessee on two points-in-time: July 31, 1991 (N = 8,467) and January 31, 1995 (N = 11,131), representing "before" and "after" snapshots of the implementation of the Tennessee Children's Plan. All children in custody on those dates were included in this study. The population, overall, was 55-58% female (see Table 1), 34-37% African-American, and spread across all age groups. Children had been committed to the custody of the following state agencies: Youth Development (15%); Education (2 - 4%); Human Services (81%); and Mental Health and Mental Retardation (< 1%).

Sources of Data

Two existing state databases were analyzed for this study. The "Modeling Utilization" project uses existing state databases and integrates information in order to be able to link services provided to children and youth by multiple agencies over time. These two databases were reviewed for equivalence of item content and variables; the comparisons presented represent those with items having good match between data sets.

Baseline survey: 1991. A baseline survey was conducted by the Tennessee Commission on Children and Youth for all children in state care on July 31, 1991. The study was designed to provide a baseline description of the population of children and youth in state care prior to the implementation of the Tennessee Children's Plan.

1995 Follow-up. The Client Operations and Review System (CORS) database was used for 1995 comparisons. January 31, 1995 was chosen as the point-in-time comparison based on completeness of the data fields of interest. CORS is maintained for all children served by the Children's Plan.

Analyses

Descriptive statistics were used to profile the similarities and differences in the characteristics of the youth. Children were identified with mental health needs if one or more of the following was present: (a) presence of a mental health diagnosis, (b) placement at any time during custody in a residential treatment center designated as a mental health setting, or (c) placement at any time in custody in a psychiatric hospital. To examine patterns of placement, the six most recent placements were arranged in sequence and resulting patterns were collapsed to form no more than 15 types of sequences.

Results

Results

First, characteristics of the children in custody in 1991 and 1995, respectively, are examined. Next, the subpopulation of children with identified mental health needs is described. The use of residential psychiatric placements and patterns of placement leading to hospitalization are then presented.

Children in Custody in Tennessee: 1991 and 1995

Of the total children in custody in 1991, almost half (47.5%) had some documented mental health need. Slightly more than half of the total were males (see Table 1). The average age of children in state care was 12 years, although those who were admitted to a psychiatric hospital were slightly older (14 years), and those admitted by a Juvenile Court Commitment Order (JCCO) were older still (15.6 years). Between 1991 and 1995, the total number of children in custody increased by almost 3,000 children. Only 35% of the children in custody in 1995 had a documented mental health need. There were only slight differences between 1991 and 1995 in the proportions who were either male or African-American, or of a given age group for the total population.

Most of the increase in the number of children in custody occurred with children who did not have a documented mental health need (from 4,451 to 7,186; a 61% increase), were male (40% increase), African-American (47% increase), young adolescents (43% increase), and were assigned to the department of human services (33% increase).

Children with Identified Mental Health Needs: 1991 and 1995

Although the proportion of children identified with mental health needs decreased (47.5% to 35%) as the total number of children in custody grew, the actual number of children with mental health needs remained relatively stable over this period (from 4,016 to 3,945). There was some slight increase in the proportions who were male (as opposed to female), or African-American, and there was a slight increase in the proportion who were age 13-15.

Children with mental health needs were in state custody an average of 761 days in 1991 and 645 days in 1995. They most often lived in foster care (44% in 1991 and 33% in 1995; see Table 2). In 1991, there were 120 children in public psychiatric hospitals (3%) and 122 in these settings in 1995 (also 3%). In 1991, there were 180 children in private psychiatric hospitals (5%), and this number dropped to 49 (1%) in 1995. The placements for Level III residential treatment centers (RTC-IIIs), which provide 24-hour care for emotional and behavioral problems, increased dramatically from 268 (7%) to 626 (16%) from 1991 to 1995.

Children in residential psychiatric treatment had been in

Children in residential psychiatric treatment had been in their current placements, on average, over 6 months (see Table 2). There was a decrease of 34 days (from 215 to 181) in the average days of placement in a public psychiatric hospital, but increases of 55 days in the length of stay in private psychiatric hospitals and 56 days in the length of stay in RTC-IIIs. The lengths of stay shown in Table 2 are slightly misleading since they include only the children who had not left those settings and therefore include those with very long stays. For those who had completed a residential psychiatric treatment for the 1995 data only, it was found that the average days in placement for completed residential treatment was 92 days for stays in public psychiatric hospitals, 89 days for stays in private psychiatric hospitals, and 163 days for completed stays in RTC-IIIs. In 1991, 22% of the children currently in public psychiatric hospitals had been there 30 days or less, in 1995 the comparable figure was 18%. The corresponding figures for private psychiatric hospitals were 32% for 1991 and 22% for 1995. For those staying over one year in public psychiatric hospitals, the percentage was 11% in 1991, and for 1995, it was 8%; and for private psychiatric hospitals 5% had stayed over one year in 1991, and 14% had stayed this long in 1995. The actual maximum days for a current psychiatric hospitalization in a public hospital were 3,378 days in 1991 and 1,076 days in 1995. The maximum days for private psychiatric hospitalizations were 771 for 1991 and 717 for 1995. In 1995, the total days of residential psychiatric care, which includes psychiatric hospitalization and RTC III placements, was 211% of that for 1991, increasing from a total of 97,044 in 1991 to 206,307 in 1995.

When compared to 1991, children in psychiatric hospitals in 1995 were more likely to be African-American (42% vs. 22%), and more likely to be in the custody of the Department of Youth Development (15% vs. 8%). Children in residential treatment centers in 1995 were more likely to be male (82% vs. 67%) and in the custody of the Department of Youth Development (24% vs. 18%) when compared to 1991. For both years, the most common diagnoses listed for children in residential psychiatric treatment were behavior problems, depression, and adjustment disorders.

Psychiatric Hospital Placements

For the 1995 data, reflecting only those children in state custody on January 31, 1995, considerably more information was available on placement history. A total of 903 children had been placed in a psychiatric hospital within the current custody period and the past 6 placements. This amounts to 8% of all children in custody and 23% of all children with mental health need who were in custody on January 31, 1995. Of those 903 children, 19% were currently (i.e., on the target date) in a psychiatric hospital (122 children in public hospitals and 49 in private hospitals). A total of 52% had been in a psychiatric hospital multiple times while in custody: 429 (48%) had only one hospitalization, 349 (39%) had two hospitalizations, 10% had 3-5 hospitalizations and 3% (26 children) had 6 or more hospitalizations. For the 171 children currently in psychiatric hospitals on the target date in 1995, this was the initial custody placement for 26 children (15%). The placement experiences since entering state custody of the children currently in psychiatric hospitals were varied:

- 23% in a private psychiatric hospital only;
- 16% in a public psychiatric hospital only;
- 4% in both public and private psychiatric hospitals;
- 10% in a RTC and a psychiatric hospital;
- 8% in an assessment center and a psychiatric hospital;
- 8% in foster care and a psychiatric hospital;
- 7% in a family setting and a psychiatric hospital;
- 5% in a Youth Development setting and a psychiatric hospital; and
- 2% in some other setting and a psychiatric hospital.

Most referrals to a psychiatric hospital might better be called transfers since the level of care or restrictiveness of the setting did not change. A full 28% of those currently in public psychiatric hospitals had come from another public psychiatric hospital program to the current setting. For current private psychiatric hospitalizations, this percentage was 27%. However, from the child's perspective, even these transfers represent an actual change in their living environment and the accompanying stressors.

Discussion

Use of restrictive, residential psychiatric placements increased from 1991 to 1995. These data indicate that the Children's Plan, while decreasing the use of psychiatric hospitals, has shifted children to longer-stay residential treatment centers. Any savings that might have been incurred through decreased use of hospitalization has been more than taken up through this increased use of RTCs. Furthermore, a significant proportion of the children in state custody experience multiple and long-stay institutional experiences.

The description of children in custody, those identified with mental health needs, and placement patterns were the focus of this summary. These are first steps needed to provide background information about the population and use of residential placements before proceeding with further efforts toward modeling service utilization and patterns of care.

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Replication of a Crisis Shelter Model of Care in Staff Secure Detention Programs

Authors

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Introduction

Historically, children have been placed in out-of-home care in alarming numbers. For example, between October 1985 and June, 1988, 102,000 youth in the US sought services in shelter care programs (US General Accounting Office, 1989). In 1990 alone, juvenile correctional facilities reported 98,000 admissions to long-term public facilities (Snyder & Sickmund, 1995). As would be expected, youth who find themselves in these settings have a variety of service needs. This summary presents preliminary evidence for the effectiveness of a model of care designed to provide safe and effective services in both short-term shelter and short-term staff secure detention programs.

Initially, Boys Town's short-term crisis shelter programs were designed to provide a safe and therapeutic environment for homeless and runaway youth in need of short-term crisis services. Over time, the mission of the shelter program changed and evolved, and the program now provides a range of short-term residential programs. These programs serve youth with a variety of residential needs, including homeless/runaway youth, troubled youth in need of a short-term residential facility, and youth in need of a staff secure detention facility.

Most recently, efforts have focused on developing strategies to serve youth in need of staff secure detention facilities. Staff secure detention programs are short-term residential settings for youth awaiting adjudication, disposition, or placement. The term "staff secure" indicates that these facilities are not locked or guarded. Currently, Boys Town operates one program designated as a short-term, staff secure detention facility in Brooklyn, New York. This facility serves only males who are referred by Brooklyn's juvenile justice system. This program is designed to reflect a guiding principle within juvenile justice: Juveniles should be housed in the least restrictive placement alternative; this is true for both short-term and long-term placement (Snyder

& Sickmund, 1995).

Boys Town currently operates a total of eight shelter programs. In this summary, data obtained from over 2,000 admissions to these programs between January, 1994 and July, 1995 are presented. These programs are located in Brooklyn, NY; Los Angeles, CA; Oveido, FL; San Antonio, TX; New Orleans, LA; Las Vegas, NV; and Grand Island, NE. The eighth program in Washington, DC opened in August of 1995; there are no data from this site to report at this time.

Method

Youth from each of these shelters demonstrate remarkable similarity in their profiles. Our research indicated that youth are all about the same age (i.e., 14 years), and have similar problems&endash;both at the individual and family level. At intake, all youth were asked a series of 37 questions regarding problems they have experienced. Of these, 11 problems emerged as the most common youth problems across all seven sites. These youth problems were best characterized as delinquent behavior, school problems, substance use issues, out of control behavior, and mental health issues. A similar pattern was evident with family stressors, with 17 stressors out of 34 emerging as the most common across all seven sites. These stressors were best characterized as substance use, criminal involvement, parental marital problems, parental financial issues, and parental discipline issues. Youth also were administered the Achenbach Youth Self-Report (YSR; Achenbach, 1991) at intake. Youth from all sites had similar YSR profiles. There was little variation among these profiles on any of the subscales or broad band scales, with none of the subscales or broad band scales approaching the clinical range. Relative to the other scales, the only subscale that showed a slight elevation was the Delinquent subscale. Although the Delinquent Behavior subscale was elevated across all sites, there was no variation among the sites on this dimension.

Results

Indicators of Program Success

One indicator of the success of these programs, both for short-term residential and staff secure detention, was the low occurrence of negative incidents as measured by an incident index. This index is comprised of 14 negative incident codes. Examples of these codes include physical aggression, out of control behavior, runaway, inappropriate behavior, suicidal gestures, etc. The average number of negative incidents per youth per length of stay ranged from 2.42 to 8.73, computed by taking the total number of incidents per site and dividing that number by the total number of youth per site. Broken down further, the average daily number of negative incidents ranged from .15 to .41, computed by dividing the average number of negative computed by dividing the average number of negative incidents per site by the average length of stay. The average number of negative incidents per youth per stay was relatively low across all sites, including the NY site which houses youth in need of a staff secure detention facility. The background of the NY site's youth might lead one to expect this site to have far more negative incidents than the other sites. Although the NY site did have the greatest number of negative incidents (.41 per day), this rate was not inconsistent with the other sites.

Another indicator of program success was the results of the satisfaction survey completed by youth. At departure from the program, all youth were asked to complete a satisfaction survey. The survey is comprised of nine items and asks questions regarding the youths' satisfaction on the following dimensions: staff fairness; freedom to discuss problems with staff; staff concern for youth; staff pleasantness; staff's efforts with helping youth to get along with others; recreation activities; counseling; contact with family; and sharing opinions. An average Overall score was computed by collapsing the subscale scores across all dimensions. The scale was based on a 7 point Likert-type scale, with 1 = completely dissatisfied and 7 = completely satisfied. Survey results were consistently high across all sites, with overall scores ranging from 5.92 to 6.23. Satisfaction ratings across all dimensions were high across all sites indicating that youth reported that they were satisfied with the program, irrespective of the program's focus.

Placement data showing whether a youth was placed in another out-of-home setting or reunified with his/her family provided an additional indicator for program success. Data was obtained for every youth at departure regarding their placement upon completion of the program. The Restrictiveness of Living Environment Scales (ROLES; Hawkins, Almeida, Fabry, & Reitz, 1992) was used to categorize these placements (e.g., group home, county detention center, foster care, etc). The percentage of youth reunified with their families ranged from 23.1% to 78.1%.

Reunification appeared to be directly related to the purpose of the shelter site (i.e., whether the shelter functioned as a short-term residential placement or not). For example, sites which operated as short-term residential facilities had a fairly high rate of placing the youth with a parent or relative at departure (FL, NE, TX, & CA). The other sites had much lower placement rates with parents or relatives, which seemed to correspond to site-specific characteristics which impacted reunification for youth served. For example, the Louisiana site served a large population of youth who were homeless due to abandonment by their parents or to situations such as incarceration of a parent. Thus, reunification was not an option for these youth. Similarly, the NY site was used as staff secure detention for many youth on their way to a juvenile detention center. Although the reunification percentage in NY was low compared to the other sites (34.4%), it is worth noting that this percentage is remarkably high given that these youth were being detained by the juvenile court awaiting adjudication.

Conclusion

In summary, these data suggest that a model of care developed for crisis shelter care can be replicated in geographically diverse locations with youth who have a variety of serious personal and family problems. These data also suggest that this model can be successfully implemented in short-term residential and staff secure detention programs.

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Evaluating the Appropriateness and Effectiveness of Long Term Inpatient Psychiatric Treatment for Adolescents

Authors

Introduction Method Results Discussion References

Introduction

With the JCAHO's "Agenda for Change" and the advent of managed care, outcome assessments have become increasingly important to psychiatric hospitals (JCAHO, 1992). In response to these new challenges, a Severity of Illness Rating Scale (SIRS) was incorporated into the clinical assessment process at Arthur Brisbane Child Treatment Center to determine the appropriateness for admissions and continued stays. Although the current field is replete with measures for assessing the clinical status of adolescents in need of psychiatric inpatient treatment, the validated measures were assessed as either not easily administered or not translating well into our decision making process regarding hospitalization (Wetzler, 1989; Boy-Byrne, Dagadakis, Ries et al., 1995). The clinical leadership selected the SIRS (source unknown at this time) based upon its ease of administration and its face validity with results directly relating to the assessment for continued inpatient hospitalization.

This study explores and speculates upon the significance of the Severity of Illness Rating Scale (SIRS) as a tool for utilization review and program evaluation. The SIRS was first introduced March, 1993 and soon became the centerpiece for the hospital's Utilization Review Plan. Since its implementation, the monthly average in-house lengths of stay at Arthur Brisbane (an intermediate to long term state psychiatric hospital) have decreased 142 days from 234 days in March, 1993 to 92 days in February, 1996. This is remarkable considering that our Hospital has not had any external managed care review process to impact upon days hospitalized.

SIRS scores have provided the following: (a) objective criteria used to determine the appropriateness of admissions and continued stays; (b) clinical profiles by adolescent, unit, facility-wide, and attending psychiatrist; (c) clinical outcomes; (d) a flagging system for special treatment reviews; (e) a vehicle to predict lengths of stay; and (f) a vehicle to validate both the facility's Mission and the clinical program design.

Method

The sample in this study consists of 63 adolescents (33 female and 30 male) who were admitted and discharged between August 1, 1994, and July 31, 1995. The adolescents were between the ages of 11 and 17 years old with a mean age of 15.2. This group was 47.6% (n = 30) white, 17.5% (n = 11) Hispanic, 33.3% (n = 21) Black, and 1.6% (n = 1) Oriental. Of the 63 adolescents, 25 were discharged to home, 10 returned to the juvenile justice system, and 28 were discharged to residential placements. The average stay of this sample was 91.2 days, ranging from 4 to 286 days.

The treating psychiatrist assigned the adolescents their SIRS scores based upon the evaluation of the adolescents' clinical condition at the time of admission and at subsequent treatment team reviews. For the purpose of this study, focus was placed on the admission and discharge scores. The SIRS scores numerically indicate the degree of functional impairment in eight separate categories of functioning: (a) affective stability (AS), (b) behavioral impulsivity (BI), (c) thought process (TP), (d) interpersonal relationships (IR), (e) problem solving skills (PSS), (f) social support network (SSN), (g) danger to self (DS), (h) and danger to others (DO). The scheduled assignment of SIRS scores translates into a profile of the adolescents' monthly progress from admission to discharge. The scores are assigned on a 1 through 5 Likert-type Scale, with 1 representing healthy functional behavior and 5 representing the highest degree of dysfunctional behavior. Thus, the higher the SIRS score the more serious the severity of illness. Scores of 4 or 5 in the italicized categories above would theoretically indicate a need for hospitalization.

The scale shares many characteristics of the Global Assessment of Functioning (GAF; Goldman, Skodal, & Lave, 1992). However, it reduces the range of responses to five anchored scores across 8 separate dimensions. Ratings by four treating psychiatrists and three covering psychiatrists completed on average two weeks apart for 16 adolescent yielded significantly correlated interrater reliability (Spearman r), with an r = .70, (p < .01). The psychiatrists subsequently attributed the differences between ratings to clinical opinion, change in adolescents' functioning, and limitation of information by the covering psychiatrist.

Results

The average admissions SIRS scores, discharge settings (DISC: 1 = juvenile justice, 2 = home, 3 = residential), and the adolescents' age proved to be reasonably good predictors the adolescents' age proved to be reasonably good predictors of lengths of stay (LOS). Using a stepwise regression procedure, these three variables account for 39% (R2 = .39, N = 63) of the variance. Table 1 presents a summary of the strength of these relationships based upon the stepwise procedure for predicting LOS.

Adolescents with higher SIRS scores, who were placed residentially and who were younger, have longer stays. The best equation for predicting LOS from this sample was: LOS = .86 + 58.33 (Avg. SIRS) + 30.94 (DISC) - 10.67 (AGE).

In regard to race, sex, or program assignment, no significant relationships were observed between each of these variables and LOS which might result in unintended variation (see Table 2).

Though gender was not significant in terms of LOS, females on average did take a little longer to place than males. The difference disappears with an average of 119 days for females (n = 31) compared to 110 days for males (n = 22) when you exclude the 10 adolescents returned to juvenile justice placements.

Conceptually, the Hospital's program design consists of the Cottage and the Main House Programs. The Cottages generally provide treatment for adolescents who externalize their behaviors and the Main House for those who internalize their behaviors. Adolescents served, however, fall along a continuum between the two points and do not fit easily into such classification. This study examined whether or not the profiles demonstrated by the SIRS scores validated this split.

Differences between the externalized and internalized programs were not as strong as initially anticipated. We expected the Main House (internalized) Program to have greater disturbance in AS and DS and less on DO. The programs, however, only differed significantly in AS. The difference in the other means, however, were in the expected direction (see Table 3).

BI, TP, PSS, IR, and SSN were tested and found not to significantly vary between programs.

The data accommodates comparisons for LOS and changes in average SIRS scores among psychiatrists, which allows for assessing practitioners' performance. Direct comparison of mean LOS's for each of the four psychiatrists demonstrated a maximum difference of 46 days with the low mean at 77 days and the high mean at 123 days. However, such a comparison needs to adjust for admissions' SIRS scores, the discharge settings, and age of the adolescents since these were found to relate to LOS. Controlling for these variables through an analysis of covariance, only a 17 day difference among the adjusted means was found with none being significantly different from the others (see Table 4).

from the others (see Table 4).

Interestingly, the longer the stays, the greater the change in the average SIRS scores. The adjusted LOS means and average changes in SIRS scores provided a meaningful appraisal of the performance of each adolescent as compared to his or her peers.

The average clinical profile upon admission described an adolescent with poor control of impulses (BI = 3.6), poor social support (SSN = 3.3), poor problem solving skills (PSS = 3.5), and who was a danger to self (DS = 3.6) or others (DO = 3.2). This profile supports the Mission of the Center: upon admission adolescents received a score of 4 or higher in at least one of the categories which was consistent with a need for continued inpatient treatment.

As would be expected, almost all adolescents improved in their average SIRS scores from the time of admission (avg. 3.3) to their final rating prior to discharge (avg. 2.8). The greatest average SIRS score improvements are noted in the categories of BI (.7), DS (.7) , DO (.6), AS (.5), and PSS (.5). All but SSN were statistically significant. Table 5 summarizes the average reduction..

This profile provides some evidence of the dimensions of adolescent functioning in which our hospital makes the most favorable clinical impact. The changes demonstrated in the average SIRS scores represent a verification of the anticipated outcomes of target goals for patient treatment planning, especially the efficaciousness of managing dangerous behaviors.

Discussion

The admission average SIRS score, discharge setting, and the adolescent's age proved to be the best organizational predictors for LOS. The SIRS scores supported the appropriateness of admissions, and to a lesser extent, program assignments. In addition, it provided a fair approach to assessing psychiatrists' performance. The SIRS scores also reported improvement from the point of admission to discharge in 7 out of 8 categories of functioning, with little improvement in SSN. The profile of the adolescents shows that the functions that are major determinants for hospitalization (i.e., BI, DS, and DO) improved the most. According to this measure, the outcomes of treatment indicated that Arthur Brisbane Hospital's treatment program design accomplished its mission

SIRS has been an effective tool in managing the care of adolescents at Arthur Brisbane. Further study is indicated to determine its applicability in acute psychiatric settings. Additional work is also needed to strengthen its reliability, which in turn, may further improve its predictive powers.

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Chapter 8

Service Utilization & Clinical Issues

Symposium

Shaping State Public Policies: Determining Access to Care and Level of Care Provided to Youth in Need of Mental Health Services

Authors

Introduction

Criteria for Accessing Child Mental Health and Substance Abuse Services in North Carolina

Proposed Eligibility Criteria and Procedures for Enrollment in Department of Mental Health Continuing Care, Procedures, References

Using the Child and Adolescent Functional Assessment Scale (CAFAS) to Establish Level-of-Need for Medicaid Managed Care Services, Method, Results, Conclusions

Criteria Used in Determining Appropriateness of Service Utilization in Arizona, Methods, Conclusions, References

Introduction

Public managed care practices are in some stage of development in each state. The implications of these policies are far-reaching, yet there is little empirical data on which to base these decisions. Criteria are being developed for determining eligibility for receiving public mental health care and for determining the levels of care that will be made available to consumers. These summaries are intended to provide examples of how state administrators have struggled with, and to some extent already experimented with, various criteria and approaches.

The systems that are taking shape in the following states will be described in detail: North Carolina, Arizona, Louisiana, and Massachusetts. Each State is using the Child and Adolescent Functional Assessment Scale (CAFAS) developed by Hodges to assess impairment in the youth's functioning. The CAFAS provides a score reflecting on the youth's functioning in eight areas: school/work, home, community, behavior toward others, mood, self-harmful behavior, abnormal thinking, and substance use. The caregivers can also be rated on two scales that reflect on the caregiver's ability to provide for the youth's material needs and for the youth's emotional and social needs. These summaries highlight the factors that are being considered for inclusion as eligibility criteria, other than impairment. The process by which these guidelines are being developed will also be discussed.

Criteria for Accessing Child Mental Health and Substance Abuse Services in North Carolina

Lenore Behar, Ph.D. & Lynn Stelle

In January 1994, the North Carolina state office of Mental Health, Developmental Disabilities, and Substance Abuse Services (NIHIDDISAS) and the local MH/DD/SA programs began a Medicaid capitated, managed care waiver program for children, under age 18, with mental health or substance abuse diagnoses. Developed jointly by the state and local entities, the waiver program, called Carolina Alternatives, has been piloted in 32 of the state's 100 counties with a plan to be statewide by 1997. All children eligible for Medicaid and in need of treatment are to be served. As a part of the changes required to operate the waiver, there have been numerous revisions in policies and procedures over the past two years. During the past six months, a committee has drafted criteria for levels of care to be authorized through the managed care program.

As a second part of the waiver program, in addition to being a statewide program for children, the capitated managed care program will be expanded during 1996-98 to include adults with mental health and substance abuse problems who are eligible for Medicaid funded services. Thus, the criteria were developed to apply to current children and to adults when that population is included in the waiver program. The following discussion will cover issues related only to the development and application of the criteria for levels of care for children. The process by which these criteria are being developed involves the following:

- First, it was important to begin operation of the program to enable service providers to gain an experiential understanding of the changes required in a managed care approach to service delivery. Staff in the local MH/DD/SA programs gained familiarity with the process of managing care, that is determining if services were needed and what services were needed and then estimating the amount of service needed to address the child/adolescent's mental health or substance abuse problems. In addition to gaining specificity in treatment planning, the staff also gained experience in learning to authorize, coordinate, and manage care with networks of other public and private providers, including inpatient settings. These new experiences provided a foundation on which to build a set of criteria that could be used to authorize build a set of criteria that could be used to authorize levels of care that were related to levels of intensity of services.

- A committee of clinical services providers, administrators, and members of consumer/parent advocacy groups was formed to develop the criteria. Starting with the levels of care criteria developed in the Fort Bragg Project, the committee made revisions they thought would clarify or improve the Fort Bragg product. They added the North Carolina Functional Assessment Scale (NCFAS) for adults and the Child and Adolescent Functional Assessment Scale (CAFAS) for children to divide clients into six categories of severity that were to be related to six levels of care. The product of the committee was reviewed by a senior level group composed of directors of local MH/DD/SA programs.
- Following approval by this senior group, the draft criteria were circulated to a wide range of stakeholders, including consumer groups, advocacy groups, professional organizations, public and private provider groups and all local MH/DD/SA programs. After receiving comments from this wide group of stakeholders, due by the end of February, a final draft will be forwarded to the Director of MH/DD/SAS as the recommended criteria for determining levels of care. It is planned that following approval from the Director and his staff, these criteria will be used for six months for a period of pilot testing. After six months of use, revisions will be made, if needed, and the decision will be made whether or not to codify the criteria into rules.

A set of six principles has been developed to apply to all levels of care. A summary of the principles follows.

- Treatment must be medically necessary.
- A deficiency in adaptive functioning must be evident and based on clinical symptoms related to DSM-IV diagnoses approved for Carolina Alternatives.
- Treatment is to alleviate problems associated with DSM-IV, Axis I diagnoses and/or to lessen manifestations of Axis II diagnoses.
- Treatment is to be provided in the most clinically appropriate level of care in the least restrictive, least intensive manner. Treatment is to be time sensitive and strength oriented and should focus on solutions, building on family strengths and resources.
- Outcomes of treatment should be improved adaptive ability, prevention of relapse, or for emergency situations, stabilization.
- The needs of the client are the primary focus of treatment. The convenience of the community, family or judiciary are not grounds for medical necessity.

Draft criteria have been developed to address six levels of care ranging from preventive services to inpatient services. Each level of care, except prevention, is accompanied by a recommended review period. For each level of care, criteria recommended review period. For each level of care, criteria are provided both for admission to the service and for continuation of the service. The levels of care including types of services and recommended review periods follows.

Prevention: respite services, after-school services, drop-in services, screening or evaluation; no recommended review period.

Level A: group therapy, high risk intervention-periodic (group), community-based intervention (group); the recommended review period is six months. The latter two categories are essentially wraparound services provided by professional staff and by nonprofessional staff.

Level B: individual therapy, high risk intervention (individual), community-based intervention (individual); the recommended review period is three months.

Level C: partial hospitalization, day treatment, case management; the recommended review period is two months.

Level D: moderate or intensive treatment in a residential setting, facility-based crisis intervention; the recommended review period is one month.

Level E: inpatient; the recommended review period is daily.

The criteria for admission to services at each of the six levels are based on severity of the child's problems. Continuation criteria are based on documentation of continued need for treatment at that level of care. Severity is determined by a CAFAS score for all levels except: (a) the minimal level which provides for the delivery of prevention services and (b) the maximum level which provides for the use of inpatient services.

1. To qualify for prevention services, the child or family must demonstrate a need for such services to prevent or delay onset of psychiatric problems in the child or to decrease the likelihood of onset.

2. To qualify for services at the inpatient level, in addition to a CAFAS score greater than 100, the child must: (1) have a DSM-IV diagnosis; **and** (2) must be considered dangerous to him/herself, dangerous to others, have a psychosis or other severely disorganizing condition, or have a life threatening medical condition (e.g., toxic drug level), or need complex diagnostic procedures or supervision of medication; and (3) constant and skilled monitoring/treatment must be provided by a physician; and (4) other less intensive services will not suffice.

As noted above, these criteria are currently under review and most likely will be modified before pilot testing. Pilot testing is scheduled to last for six months, or possibly more if needed, so that there is confidence in and comfort with the if needed, so that there is confidence in and comfort with the application of these criteria to clinical services.

Proposed Eligibility Criteria and Procedures for Enrollment in Department of Mental Health Continuing Care

Elizabeth Irvin, Ph.D. & Phyllis Hersch, Ph.D.

Legislation referred to as Chapter 599 established the primary mission for the Massachusetts Department of Mental Health (DMH): "to provide services to citizens with long-term or serious mental illness." This requires the Department to target programs and services to persons with long-term or serious mental illness. Therefore, the primary mission of DMH is to direct its services to adults with serious or long-term mental illness and children and adolescents with serious emotional disturbances. These priority clients may access continuing care services funded by or provided by the DMH.

The purpose of this summary is to describe the clinical assessment criteria and procedures being proposed by the Department of Mental Health to assess the eligibility of children and adolescents for enrollment as priority clients in DMH continuing care services. Inclusion in the target population defined by these criteria is based on the presence of a serious emotional disorder that has resulted in functional impairment that substantially interferes with or limits the performance of one or more major life activities. These criteria integrate federal definitions for serious emotional disorder with the Department's current eligibility guidelines for children and adolescents.

Youth applying for any DMH-funded service will be assessed for their level of need for mental health services using the criteria described in this document. Based on the findings from the assessment, children and adolescents who meet eligibility criteria will be enrolled as a DMH continuing care client and assigned to a Care Management site for treatment planning and service authorization. Care management sites are located in communities across the state and are part of the Comprehensive Community Support System of Services. Care Management personnel provide clinical oversight, care planning, service authorization, service coordination, referral, and advocacy for eligible, enrolled members. All DMH services are authorized through Care Management and are targeted to level of need and provided within available resources.

Although all youth whose continuing care services are funded through DMH must fall within the eligibility criteria described in this summary, there is no intention to restrict the flexibility or responsibility of the Department of Mental Health or the Division of Medical Assistance to tailor publicly funded service systems to meet local mental health needs and priorities.

Proposed Definition of Children and Adolescents with a Serious Emotional Disorder

To be determined eligible for DMH services, children and adolescents must have a diagnosable mental, behavioral, or emotional disorder that has resulted in significant functional impairment. Specifically, to qualify for continuing care services through the Department of Mental Health, the youth must be 18 years of age or younger at the time of application and have a qualifying mental, behavioral, or emotional disorder of sufficient duration to meet criteria specified within the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV; APA, 1994). The qualifying disorder must have existed for at least six months prior to application and be expected to last for at least one year, and the disorder must have resulted in functional impairment which substantially interferes with or limits the youth's role or functioning in family, school, or community activities. The service history of youth meeting these eligibility criteria will be reviewed prior to final approval for enrollment.

For purposes of determining eligibility for DMH services, a child or adolescent with a serious emotional disturbance is one whose progressive personality development is interfered with or arrested by a variety of factors so that there is impairment in the capacity expected, given the child or adolescent's age and endowment. All of these disorders have episodic, recurrent, or persistent features; however, they vary in terms of severity and disabling effects. Thus, children and adolescents with serious emotional disturbances will have a diminished capacity to reasonably and accurately perceive the world around them, control their impulses, maintain satisfying or satisfactory relations with others, and/or to learn. Serious or long-term emotional disturbances include schizophrenia and disorders of affect and personality, as well as other qualifying disorders depending on the severity and duration of the illness. Children and adolescents with serious emotional disturbances may have disorders of impulse control or attention deficit. However, all youth meeting the general eligibility criteria must also meet the functional impairment criteria. The five eligibility criteria contained in this definition are further defined below:

Criterion A: Qualifying Mental Disorder. Qualifying mental disorders are all disorders listed in the DSM-IV with the exception of those specifically excluded. Excluded disorders are usually first diagnosed in infancy, childhood, or adolescence, and include, but are not limited to mental retardation, pervasive developmental disorders, and autism. Also excluded are (a) conditions categorized under Delirium, Dementia, Amnestic, and Other Cognitive Disorders; (b) mental disorders due to a general medical condition; and (c) conditions listed under Substance-Related Disorders. While mental health practitioners are frequently involved in treatment planning and service delivery for involved in treatment planning and service delivery for these children and adolescents, separate Federal block grant funds and processes for needs assessments address these population groups.

Criterion B: Duration of Qualifying Disorder. The qualifying mental, behavioral, or emotional disorder shall have existed for six months prior to application and be expected to last for at least one year.

Criterion C: Functional Impairment. Functional impairment is defined as difficulties that substantially interfere with or limit a child or adolescent from achieving or maintaining one or more developmentally appropriate social, behavioral, cognitive, communicative, or adaptive skills. Functional impairment of episodic, recurrent, and continuous duration are included unless they are temporary and expected responses to stressful events in the child or adolescent's environment.

Operationally, functional impairment related to a qualifying behavioral, emotional, or mental disorder will be evaluated using standards outlined in the Child Adolescent Functional Assessment Scale (CAFAS: Hodges, 1994). The results of an evaluation using these standards will determine if the applicant meets functional impairment criteria for enrollment in DMH continuing care; specific impairment thresholds for eligibility are under study and will be described once the Youth Eligibility Pilot is completed (April 15,1996).

Criterion D: Duration of Severe Functional Impairment. This is an indication of how long the youth has been functioning in the severely impaired range. Severely impaired functioning may be a relatively constant feature of the youth's disorder, or may come and go. The period of impairment need not be consecutive. To determine the duration of severe functional impairment, the cumulative number of months during the past year that the youth was dysfunctional, as identified by the CAFAS, is utilized.

Criterion E: Service Utilization. Applications will be reviewed for the adequacy of services the youth received in the six months prior to referral. Insured youth who meet eligibility criteria for Groups 2 or 3, who have not been offered services matched to their level of need and ability to utilize such services during the six months prior to referral, may at the discretion of the Department, not be enrolled in DMH-funded services until appropriate interventions have been tried in the community.

Procedures

Standardized criteria are used to evaluate eligibility for DMH services and to classify eligible applicants into one of four clinically related groups. The criteria are: (a) diagnosis, (b) duration of illness, (c) severity of functional impairment, and (d) duration of severe functional impairment.

The general approach is to establish that the youth meets clinical criteria for a qualifying DSM-IV psychiatric diagnosis and that the youth is functionally impaired as a result of the qualifying disorder. Using duration of functional impairment criteria, eligible youth are then classified into one of three clinically related groups: *Severe and Persistent Mental or Behavioral Disorder* (Group 1), *Severe Mental or Behavioral Disorder* (Group 2), and *Moderately Severe Mental or Behavioral Disorder* (Group 3). Youth who meet eligibility criteria for Groups 1, 2, or 3 are also evaluated with regard to their prior services. Youth who have not had services matched to their level of need during the six months prior to referral, may at the discretion of the Department, not be enrolled until appropriate interventions have been tried in the community. The Department reserves the right to enroll persons who require advocacy to access the full benefit of their insurance.

Eligible service recipients will be enrolled regardless of their ability to pay. Third party reimbursement or client funds will be accessed when service recipients have this alternative available prior to use of DMH funds. Enrollment in DMH continuing care does not constitute an entitlement for, or a guarantee of services. Youth enrolled in DMH will be served based upon available resources, and services will be available to priority clients most in need of those services. DMH services may be terminated once the youth no longer requires continuing care services using standard criteria.

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Using the Child and Adolescent Functional Assessment Scale (CAFAS) to Establish Level-of-Need for Medicaid Managed Care Services

Randall Lemoine, Ph.D., Tony Speier, Ph.D., Sally Ellzey, BCSW, & Jo Pine, MSW

Over the past two years, the Louisiana Office of Mental Health (OMH) has initiated public managed care practices in an effort to better manage costs and to promote quality of services for Medicaid-funded programs. These practices have included prior-authorization for services based on target population eligibility and level-of-need criteria; allocation of a fixed amount of services based on assessed allocation of a fixed amount of services based on assessed level-of-need; and ongoing monitoring of service utilization and outcomes. OMH initiated these practices statewide for case management services in 1994 and recently designed a significantly enhanced program for mental health rehabilitation services, enabling a very flexible but managed wraparound package of services. The CAFAS was selected as the instrument to establish the initial level-of-need and to monitor changes in child/family need and outcomes over the course of service. Wraparound service packages were designed for child/families with high, medium, and low levels of need as assessed by the CAFAS. This summary paper will discuss the selection and use of the CAFAS for this program which was implemented in December, 1995.

Method

The Medicaid Mental Health Rehabilitation (MHR) program was implemented statewide in Fiscal Year (FY) 1992 as a fee-for-service program serving both adults with serious mental illness and children/youth with severe emotional/behavior disorders. It was designed to supplement the existing array of OMH clinical and case management services and to offer a broad range of treatments and supports in natural community settings (e.g., home, school, etc.) outside the clinic environment. These services included both traditional clinical and more contemporary psycho- social rehabilitation services. For example, individual, group, or family psychotherapy could be offered as well as psycho-social skills training and a range of support services (i.e., professional and paraprofessional), as long as these did not duplicate clinic based services. OMH viewed this program as providing the basis for future development of a comprehensive, community-based service array. The program was initially administered and monitored completely through the state Medicaid agency.

The MHR program showed tremendous growth over the three year period of FY 92-95, increasing from an initial $6M program to a $35M program. By July, 1995, there were about 335 providers and nearly 8,000 children/youth served statewide. Whereas this growth could have been considered positive in terms of increasing the amount of mental health services available to children/youth in the state program, reviews indicated that there were actually widespread program abuses. There was increasing concern that this program was on a "runaway course." The growing provider network was largely inexperienced with delivery of individualized, wraparound services in natural settings, and many agencies appeared driven more by the "business opportunity" of the program than by an interest in delivering quality care. Program reviews indicated that the service population included large numbers of children/youth who did not meet target population eligibility criteria of serious emotional/behavioral disorder, and services were fragmented.

During this time, the state also experienced a severe budget crisis which affected all Medicaid programs. With regard to the MHR program, the legislature slashed the program budget for the coming FY 96 from $35M to $12.9M, a 63% reduction, and required that it be capped at that level funding. The legislature further required that the program expenditures be audited monthly and gave the state Medicaid agency 180 days to "fix" the program or eliminate it. The fiscal crisis and the program abuses that preceded provided OMH and the Medicaid agency with an opportunity and incentive to redesign the program utilizing public-based managed care practices to contain costs, promote quality, and to protect the scarce dollars remaining for the children/youth most-in-need of this service.

The redesign took place very quickly in two phases, the first being the "quick fix" to gain immediate program control, and the second, and the subject of this summary, initiating a more sound and permanent program design that included several enhancements to promote quality and outcome of care. The entire redesign process was done in a close partnership with the Medicaid agency, based on the foundation of the prior positive experience observed in the successful case management program. During Phase I of the redesign, OMH became an administrative agent of Medicaid, as had been done previously with case management, and utilized its experienced regional prior-authorization (PA) staff (most of whom were seasoned OMH clinicians) to pre-certify cases based on explicit target population eligibility criteria (i.e., diagnosis, disability, and duration). This step alone was quite effective in assuring children/families most-in-need were receiving services.

Under Phase II, each agency was to offer a comprehensive, wraparound plan of professional and paraprofessional services through pre-established service packages based on the child/family's assessed levels of need for the service. Three tiers of service packages were designed: High, Medium, and Low (i.e., High being intensive and Low being the maintenance level). In order to assure a uniform and complete data base for target population and level-of-need eligibility determination by PA staff, OMH required provider agencies to submit a standardized clinical evaluation completed by both a psychiatrist/psychologist and social worker. Finally, a case-rate payment methodology was developed to pay provider agencies for the menu of services delivered.

A key component of the redesigned program was the assessment of level of need (LON). This required an instrument that would enable OMH regional PA staff to reliably assess the child/family current service need levels based on data submitted by the provider. OMH needed an instrument that was relatively brief, but comprehensive and sound. The instrument also needed to have adjustable leveling criteria and be utilized relatively objectively, yet still be rated from clinical records. The development team reviewed other states' experience in use of LON technology.

reviewed other states' experience in use of LON technology. Only a few states had begun to employ LON technology, but those that did were utilizing multidimensional level-of-functioning instruments to assess need in addition to target population eligibility criteria. The OMH development team was impressed with North Carolina's Level-of-Eligibility (LOE) approach, using the Child and Adolescent Functional Assessment Scale (CAFAS). This approach had an established track record for identifying eligibility and service levels along with other pertinent factors, and the CAFAS had undergone impressive recent developments (Hodges, 1994). In addition, the CAFAS included both child and caregiver scales, so that family issues could be incorporated into the LON ratings. After some initial piloting, the CAFAS (1994 version) was selected for use. In order that the selection of cases to be served would be sensitive to both child and family needs, OMH decided to utilize the combined total of the five youth clinical and two caregiver scores as defining the overall LON.

Because the program budget was so limited, a difficult administrative decision had to be made to first serve only those child/youth that rated at a high LON. It was understood that if more money was made available and added to the program later, OMH would have the ability to serve persons at the moderate and low levels of need at program entry.

All remaining MHR cases (N = 551) were rated by PAs using the CAFAS. The distribution of scores was reviewed to determine the cut-off points that would be used for high, medium, and low levels. In setting the levels of need based on the CAFAS total ratings, OMH was guided by what had been previously used by North Carolina for level of eligibility criteria and by the established CAFAS guidelines for total of the youth scales.

Results

The distribution of total CAFAS scores (combined total youth and caregiver scores) was normally distributed and showed a mean, median, and modal rating of 90, with a standard deviation of 30. A total score of 90 on the youth scales alone has been utilized in North Carolina for Level I, the highest of the four levels of eligibility. Since 90 was the mean and modal level for the select group of child/youth known to meet target population eligibility by prior-authorization, OMH determined that the high level score cutoff would have to be above this level. A total CAFAS score of 120 would be about one standard deviation above the mean. A score of 60 would be one standard deviation below the mean. So OMH decided on levels at 120 or above for High, 60 to 110 for Medium, and 50 or below for Low. This resulted in 23% (or a total of 120) of then active cases being classified as High and eligible for the program at the time of re-implementation. These score cutoffs were considered meaningful by the PAs based on their personal experience with the assessment data for cases they were rating. The redesigned program was implemented in December, 1995, using these cutoff scores.

Conclusions

Program reviews over the early stages of this program have indicated that the combination of target population eligibility criteria and level-of-need, as measured by the CAFAS, has been working well in identifying those most-in-need for the service. In addition, much is being learned about applying level-of-need technology. There have been ongoing discussions regarding the concept of LON and how it may be further developed. One important consideration is that LON is based solely on current level of functioning or impairment, which is subject to a variety of influences, especially the existing level of services/supports received. Several provider agencies argued that children/families with high-needs did not score at the High level because they were receiving a level of services at the time of the rating which lowered their CAFAS score; that is, maintained them at the moderate or low levels. How to adjust the LON to accommodate for existing services/supports at the time of program registration has been an issue under study. OMH has also been studying the use of the Caregiver Scales in the LON determination and how ratings on these scales interact with the youth scales.

Some agencies have argued that youth with serious disturbances and fairly functional families do not meet the high level-of-need criteria. Some PAs have suggested weighting scales separately. Similarly, some PAs have recommended scoring each of the Role Performance sub-domains (i.e., home, school, and community) areas separately.

A child with a severe rating on two or more of these subscales is much more in need than one with severe rating in only one. Finally, it has been noted that the CAFAS does not appear to be as sensitive to high needs at preadolescent age levels as it is for adolescents. This may be attributed to scores reflecting impairment appropriate for these age groups. In other words, there is more opportunity to score higher or be rated as more impaired on the CAFAS as the child grows older.

OMH will be continuously refining and improving this program and the level-of-need methodology over the coming year. The authors are hopeful that our experience will not only put this program on a sound foundation but also is paving the way to quality, managed, community-based mental health services for children/youth and families in need in Louisiana.

Criteria Used in Determining Appropriateness

of Service Utilization in Arizona

Aimee Schwartz, M.D. & Stephen Perkins, M.A.

For the past several years, the Division of Behavioral Health Services of the Arizona Department of Health Services (ADHS/BHS) has mandated the use of the Child and Adolescent Functional Assessment Scale (CAFAS; Hodges, 1994) to determine the need for case management for children and adolescents. A score of 90 or higher, not including the caregiver scales, has been used to qualify children and adolescents for Intensive Case Management services. An override is also in place, in the event the child did not qualify by a 90 CAFAS score, but requires case management services. The Division of Behavioral Health Services also uses the Arizona Level of Functioning Assessment (ALFA), which is based on the Colorado Client Assessment Report (CCAR; Ellis, Wilson, & Foster, 1984) to capture functional levels for both adults and children.

The Arizona behavioral health service system plans to enhance the case management process by establishing three phases of case management. The first phase is provided for children and adolescents in multiple child-serving agencies who have a history of repeated use of restrictive services and treatment non-compliance. The second phase is for those children and adolescents requiring ongoing support to access treatment services. The third phase, case coordination, is for those children who are able to improve with brief intervention, or who will improve with minimal intervention.

Methods/Procedures

To better discriminate the child's level of need, BHS is considering enhancing use of CAFAS or ALFA scales with the addition of a diagnostic classification system to suggest level of functioning, service level, and treatment intervention for children and adolescents.

This usage would replicate the Adult Mental Services Level Checklist, which is an instrument that was originally designed in 1992 for determination of Adult Seriously Mentally Ill (SMI) and service level need for the adult population. As mentioned above, the Arizona Level of Functional Assessment (ALFA) for adults provides function measures based on the Colorado Client Assessment Report (CCAR).

The first step would be determination of the diagnostic classification. The DSM IV Axis I and II principal diagnoses have been separated into four categories: major biological disorders, disorders requiring specialized reviews, other diagnoses not requiring specialized reviews, and those diagnoses typically associated with children being served through other non-mental health related services.

Category I includes diagnoses occurring with major biological disorders, including Bipolar Disorders, Major Depression, Schizophrenia, and other diagnoses of a biological nature.

Category II includes those diagnoses which may require specialized reviews. Disorders such as conduct, depressive, identity, and borderline personality may require further review for secondary diagnostic codings. Disorders falling into this group often coincide with other diagnoses and many times require different service interventions than the Category I group.

Category III includes other diagnoses that have initial onset in childhood, and do not require specialized reviews for secondary diagnoses or other symptomatic reviews.

The final Category, IV, includes those diagnoses that are typically found in children involved in other child-serving agencies. Conduct Disorder, although typically found in children served by multiple agencies, is classified only in Category II due to its requirement for specialized review.

The second step of the service level determination process would utilize either the ALFA or CAFAS scores. The CAFAS consists of eight scales describing the youth's functioning and two that rate the youth's family/caregiver. Six of the CAFAS scale (or five of the ALFA scores) would be summed to yield a total that is used to help determine the appropriate level of case management services. When the CAFAS is used, School/Work, Home, Community, Behavior Toward Others, Substance Use, and Family/Social Support scales would be conceptualized as functional indicators. Since each scale is rated on a four point scale (i.e., 30, 20, 10, 0), the range of scores for these six CAFAS scales is 0 to 180, with higher scores reflecting greater impairment.

The two remaining CAFAS scales used to rate the youth (i.e., Mood/Self-Harm and Thinking), would not be considered in determining service level. Rather, they could be used in conjunction with the diagnostic classification to predict and aid in determining the type of service intervention rather than the service level.

The three service levels correspond to the three phases of case management. First level services, including phase one case management, are for those children and adolescents scoring over 120. Service level number two, including phase two case management, are for those children and adolescents scoring between 70 and 120. Those children receiving under a 70 functional score are able to receive level three services.

Assigned service levels are also an option when service providers do not agree on the predicted service level. This allows for the child to receive a different level of case management. This overrule will be in effect until such time that State officials determine the appropriate cutoff scores for the service levels.

Conclusion

This service level determination process will be developed and piloted statewide for a six-month period. At the time a review of the service utilization and grouping of children based on diagnoses and functioning levels will be conducted. A review of the "assigned service levels" will be compared to the "predicted service levels" to determine appropriate cut-off scores for the three service levels. Six month data will be used to determine appropriateness of CAFAS scales versus ALFA scales used to determine the three service levels. Cluster analysis of these scores will be conducted based on the "assigned service levels." These "assigned service levels" will then be compared to the "predicted service levels" to determine appropriateness of established cutoff scores for service levels.

Determination of service level is anticipated to provide state reviewers an opportunity to conduct desk audits of services being provided to groups of children and adolescents. In addition, the process should help case managers better define the array of treatment interventions that may be required for children and adolescents.

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The Effects of Conflict and Marital Status on Child Behavior

Introduction

Although divorce is generally considered a risk factor for the development or exacerbation of children's behavioral and emotional problems (Buchanan, Maccoby, & Dornbusch, 1991; Fine, Morelad, & Sachwebel, 1983), family conflict and marital discord may be equally or even more detrimental to children's well-being (Garber, 1991; Long & Slater, 1988; Tschann, Johnston, Kline, & Wallerstein, 1990; Wallerstein, 1991). Thus, the effects of marital conflict may supersede the benefits of a physically complete family unit. We sought to replicate the findings of these studies in a racially/ethnically and socio-economically diverse, urban child guidance setting. We hypothesized that family conflict would account for significant variance in predicting childhood functioning over and above the influence of marital status (i.e., married, divorced, or separated) and other demographic variables.

Method

The sample consisted of 95 children applying for clinical services at the Yale Child Study Center Outpatient Clinic. The children ranged in age from 3 to 17 years (M = 9.3) and represented a number of racial, ethnic, and social backgrounds (see Table 1). Forty-nine children (52%; 24 boys/25 girls) were from families in which the custodial parents were currently married, 33 (35%; 18 boys/15 girls) were from divorced homes, and 13 (14%; 7 boys/6 girls) came from homes in which the parents were separated. In total, three-quarters (n = 71) of the children were Caucasian and one-quarter (n = 24) minority.

Following a phone intake interview during which general demographic and symptom data were gathered, parents were mailed and asked to complete the Family Environment Scale (FES; Moos & Moos, 1986) and the Child Behavior Checklist (CBCL; Achenbach & Edelbrock, 1983). During an initial evaluation period, intake clinicians assessed and provided estimates of children's global functioning using the Children's Global Assessment Scale (CGAS; Shaffer et al., 1983) and the Global Assessment of Functioning scale (GAF; Diagnostic and Statistical Manual of Mental Disorders-III-R, 1987).

Results

Preliminary Analyses

In order to assess group (married, divorced, separated) equivalence on demographic variables, omnibus chi-square analyses were conducted. Results indicated significant differences in social class [Hollingshead Five Factor Index of Social Status (1975) was collapsed into three categories], c2 (4, N = 91) = 12.05, $p < .05$, and geographical location (urban vs. suburban), c2 (2, N = 95) = 15.17, $p < .001$. Differences in ethnic distribution (Caucasians vs. minorities) among the three groups approached but did not reach statistical significance, c2 (2, N = 95) = 5.40, $p < .07$. (see Table 1 for specific cell counts and percentages). The three groups did not differ in terms of child age, gender, or referral source (formal/coercive vs. informal/non-coercive; see Table 2).

In order to compare the functioning of children from married, divorced, and separated families, the means of these three groups on the CBCL, CGAS, GAF, and Conflict subscale of the FES were examined using Oneway Analysis of Variance (ANOVA); Tukey's Honestly Significant Difference Test was used for comparisons between the three groups (see Table 2). Results indicated no statistical differences between the three groups on any measures as rated by the parent or clinician. Furthermore, there were no significant differences between minorities and non-minorities on these measures of child behavior, functioning, and family conflict.

functioning, and family conflict.

Main Analyses

In order to examine our primary hypothesis that family conflict would contribute unique variance in predicting child functioning and symptom level, we conducted hierarchical regression analyses in which SES, child race, gender, and age were analyzed as a first block, followed by marital status in a second block, and then family conflict on block 3. In this way, we accounted for the variance attributable to demographic variables and marital status before considering the influence of family conflict. Findings indicated that family conflict made an additional, unique contribution in predicting child externalizing problems and total symptom level. However, family conflict was not predictive of internalizing problems or global functioning as rated by the clinician. Furthermore, marital status did not make a significant contribution in predicting child functioning on any of the dependent measures after demographic variables were entered.

Discussion

The current work partially replicates the findings of previous studies that demonstrate the impact of familial conflict on child impairment over and above marital status. Specifically, we found that family conflict predicted child externalizing behavior as reported by the caretaker (usually the mother). Family conflict was not predictive of internalizing problems as reported by the parent nor of functioning as rated by the clinician. One might hypothesize that children in stressful family situations often become the recipients of parental projections and thus become viewed negatively by caretakers (Armbruster, Dobuler, Fischer, & Grigsby, 1996). Although level of conflict may have influenced a parent's perception of the child's externalizing problems, reported familial conflict did not appear to affect the clinician's assessment of the child's functioning. This finding once again highlights the importance of considering the informant when evaluating children's pathology (see Achenbach, McConaughy, & Howell, 1987) and appears consistent with other studies which have found that mothers tend to over-report negative child behaviors (Christensen, Margolin, & Sullaway, 1992).

In the current environment it is important to note that minorities and non-minorities in our study did not differ in behavior and functioning as rated by caretakers and clinicians. This is important in light of the finding that minorities are often perceived as having more severe impairment than non-minorities (Cheung & Snowden, 1990). Future studies may want to examine the relation of ethnicity and child/family pathology within separate marital categories.

A major limitation of our study is the absence of father and child reports of behavior, as well as ratings of parent psychopathology. Such information may shed light on why psychopathology. Such information may shed light on why caretaker's perception of conflict predicts externalizing but not internalizing problems. We hope to include such measures in future studies that will allow us to examine the complex relationships between child impairment, different informants, and caretaker's psychopathology across child's gender, race, SES, and age.

See Table 3 for Regression Analyses.

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Symposium:

Treatment Beyond Ten Visits Must Be Determined To Be Necessary

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Introduction Diagnostic Systems Economics and Jails Adolescent Mental Health Service Use Conclusions

Shortcuts

Introduction

Managed mental health services, including child mental health services, are rapidly becoming the norm in the United States. This is particularly the case for public child mental health services previously funded through Medicaid, Title XIX. There are expectations of greater cost and operational efficiency as well as possibly greater effectiveness in the delivery of child mental health services through this model. On the other side, there are serious concerns and apprehension that this model will be misapplied, leading to reductions in child mental health services just as they were beginning to go beyond meager levels.

In this conversion to the managed care model and planning for new service systems, little attention has so far been paid to results from child mental health epidemiological and services research. This developing body of literature points to (a) high levels of mental health service need in child and adolescent populations; (b) how such need is not addressed as a result of a number of limitations in the existing service system; and (c) how children and youth in need of mental health services are shifted into other service sectors (e.g., juvenile justice, social services, education, etc.), defeating any efforts at cost containment. Whether the designers of managed care systems for children and their families attend to these cautionary tales will determine their actual success or failure in reaching their proposed outcomes.

In this summary, findings from three studies are briefly described to illustrate the perils around which managed care must navigate in order to construct effective systems of care for children and youth.

The Role of Diagnostic Systems

Theodore Fallon, M.D., M.P.H. & Mary Schwab-Stone, M.D.

This study examined the perils involved in the use of categorical diagnoses to identify who is in need of care.

Methods

The study sample included 219 school children ages 6 to 12 years chosen from a general population in urban and rural Eastern Connecticut. The sampling techniques were designed to mimic a random sample of the population over sampled for psychopathology. This epidemiological survey is remarkable for the acquisition of three informants for each child (i.e., the parent, a teacher, and the child). Each informant was interviewed with the Diagnostic Interview Schedule for Children; as well, other instruments assessing the school, neighborhood, and family environment were applied. The interviewer also assigned a Children's Global Assessment Scale (CGAS) score to each child interviewed, depending on their level of function. The diagnosis of Attention Deficit Hyperactivity Disorder (ADHD) was used to explore the effect that informant disagreement has on determining categorical diagnoses. The DSM-III-R criteria of the presence of at least 8 of 14 symptoms was used as the definition of ADHD. The information from the three informants was then combined in 12 different ways using one, two, or all three of the informants.

Results

Similar to the clinical situation, disagreement among informants was common in this data set. Depending on which informants were queried and how the information from the informants was combined, anywhere from 3% to 62% of this general child population sample could be diagnosed as having ADHD. This large variation in prevalence occurred despite using the same DSM-III-R criteria for ADHD. Also, depending on which algorithm was used, the average CGAS score varied between 55 (significantly disturbed) and 72 (only mildly disturbed).

Discussion

The results of this data analysis demonstrated that criterion-based diagnoses are limited in their ability to determine which children are in need of treatment. In fact, given the DSM-III-R diagnostic criteria for Attention Deficit Hyperactivity Disorder, a managed care organization could choose to provide services to 62% of a general population or to deny care to all but 3% of the group, depending on how they interpreted the information. Considering the process at the clinician level, it is important for practitioners to recognize the diagnostic ambiguities that remain even after assigning a diagnosis.

The Role of Economics and Jails: Access and Outcome for Under-Served Youth

Andres J. Pumariega, M.D.

This study illustrates that entire populations can be overlooked when considering who needs care.

Methods

This study examined two population samples. The first sample included a school-based sample of 2585 youth in a tri-ethnic population in two regions of Texas. A Youth Self Report was used to survey this group. The second sample included an incarcerated youth population and a community mental health treated group of youths, both from South Carolina. This second sample was surveyed using the Diagnostic Interview Schedule for Children version 2.3 and the Child Behavior Checklist (CBCL). Youth who met diagnostic criteria on one diagnosis on the Diagnostic Interview Schedule for Children 2.3 and had a total t score of greater than 70 on the Youth Self Report were identified as having significant psychopathology. Both populations were also given questionnaires eliciting demographic variables and mental health service utilization.

Results

In the first sample of school youth from Texas, service utilization amongst this tri-ethnic sample never rose above 30 percent, even in children with total t scores over 80 on the Youth Self Report. Although ethnicity and access to services appeared to be the major factors influencing service use, multiple regression analyses indicate that socioeconomic factors were the strongest determining variables.

In the second sample, the two groups (i.e., incarcerated youth versus community mental health treated youth) had almost identical prevalence of significant psychopathology (53% for incarcerated youth versus 56% for community treated youth); however, incarcerated youth had significantly lower prior utilization of mental health services and higher utilization of long term residential services.

Discussion

The result suggest that youth from low socioeconomic populations are under-served, and that in fact the poorer they are, the less they are provided for, even for those youth who had the most severe disturbances. The youth from this group with the most severe disturbances are especially vulnerable, and most likely to end up in the juvenile justice system. Results from the second study suggest that despite need (significant psychopathology), these children receive even fewer mental health services and that there is cost shifting from mental health services to juvenile justice shifting from mental health services to juvenile justice services.

A Longitudinal Study of Adolescent Mental Health Service Use

Steven P. Cuffe, M.D., K. Jackson, A.B., J. Waller, Ph.D., S. Chilappagari, M.D., C. Z. Garrison, Ph.D., C. Addy, Ph.D., R. McKeown, Ph.D.

There is a paucity of research on the patterns of mental health service use in community samples of adolescents. Existing evidence suggests that most children and adolescents with psychiatric disorders receive no treatment and that older adolescents are much less likely to receive treatment than younger children. We report on mental health service use data from a longitudinal, school-based, epidemiologic study of adolescent depression.

Methods

From 1986-1988, a total of 3283 7th, 8th, and 9th graders were screened with the Center for Epidemiologic Studies Depression Scale (CES-D). The top decile of CES-D scorers and a random sample of the remainder were interviewed using the Schedule for Affective Disorders and Schizophrenia for School-aged Children (K-SADS). Two waves of interviews were performed. The first wave (N = 478) was conducted immediately following the screening while the subjects were ages 12-15 , and the second wave (N = 490) was administered from 1992-1995 while the subjects were aged 17-20. Finally, a thorough assessment of service use and perceived barriers to care was performed via a telephone survey (N = 344) and questionnaire (N = 330) during late 1994 and 1995 when the subjects were aged 19-22.

Results

A dramatic decrease in the frequency of professional contact for emotional problems was found over the course of adolescence from 22% of the sample in early adolescence to 9.1% during late adolescence to 3.2% in late adolescence/early adulthood. Caucasians and males were more likely to receive treatment in wave one, with African-American females having significantly lower service use in the multi-variable model. The differences in service use between races narrowed over the course of adolescence. Gender differences in the use of mental health services also changed significantly over time. In wave two, service use was almost equal among males and females, while in the most recent survey, females were significantly more likely to receive treatment than males ($p = 0.02$). In the barrier questionnaire, 80% of the respondents reported that financial issues were a barrier to obtaining treatment. Over half the sample stated a preference for using family, friends, ministers, or family doctors for help with their emotional problems. Finally, approximately one third of the sample endorsed privacy or stigma issues and lack of knowledge of where to obtain help. In a regression analysis, it was demonstrated that African-American females report significantly more money barriers, females report significantly fewer work barriers, and Caucasians significantly more knowledge barriers.

Discussion

These data suggest that most adolescents with psychiatric disorders fail to receive treatment. There are significant differences in both service use and perceived barriers to services by race and gender. There is a clear need for increased accessibility and cultural sensitivity in the provision of mental health services. There are many lessons and dilemmas posed for managed care companies by these data. Under-use of services by adolescents experiencing emotional or behavioral problems may reduce the immediate costs to health care companies. However, the long-term functioning of these individuals may be poor, resulting in far greater costs to the companies over time, assuming a no eject, no reject policy requiring companies to take responsibility for the health care of their customers. Outcome data is needed to evaluate the efficacy of treatment, and to assess productivity, as well as overall service use costs. Research in the area of early intervention and case detection is sorely needed. Managed care companies should also investigate the significant decrease in service use in late adolescence and take steps to reduce the barriers to care for this group. Finally, consumers and advocacy groups should demand improved accessibility and culturally sensitive care.

Conclusions

The developing systems of managed mental health care hold important potential for systems of care for children and adolescents. With coordination of efforts and intelligent allocation of services, children's service systems hold great promise. However, these three studies demonstrate that there are many perils facing the development of managed mental health care. If we close our eyes to these perils, efforts to provide efficient and effective care for children have a significant potential to go awry.

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What the Literature Tells Us: Relationships Between Family Violence, School Behavior Problems, Juvenile Delinquency, and Adult Crime

Shortcuts

Introduction

Childhood victimization and the witnessing of violence in the family have substantiated short- and long-term negative consequences for child and adult behaviors. The deleterious physical and emotional impact on children and families of violence in the home, community, and school is a serious problem. Correlations between family violence, child abuse and neglect, school behavior problems, juvenile delinquency, and criminal activity have been documented. However, there is limited empirical knowledge in each of the areas and even less when inter-relationships among the areas are explored. The purpose of this paper is to construct a multi-systemic picture of the impact of family violence on children, families, and society through the empirical literature in these areas and their inter-relationships.

A review of the literature is important as a framework upon which to construct future research, practice, and policy. A search of the psychological, sociological, educational, medical, and dissertation indexes of literature over the past 15 years provided a broad representation of the empirical research on family violence. Additional research is needed, especially prospective studies that consider questions regarding methodological issues.

Violence in the Family

The "cycle of violence," "violence begets violence," and "intergenerational transmission of violence" are phrases that are often used interchangeably in the literature to refer to children who were abused becoming abusers or violent offenders, and more recently, witnesses of family violence becoming victims or violent offenders. Although most survivors of childhood maltreatment do not have a criminal record, a longitudinal study of abuse demonstrated that those who were abused or neglected as children were 58% more likely to be arrested as juveniles, 38% more likely to be arrested as adults, and 38% more likely to be arrested for a violent crime (Widom, 1989).

The term family violence has often been used to focus specifically on marital violence. Researchers and practitioners have broadened the field's scope and the public's awareness by identifying family violence as all violence that occurs in the family. Family violence includes child abuse and neglect, spouse abuse, sibling abuse, courtship abuse, elder abuse, and violence witnessed in the home. The following sections describe the relationship of many of the manifestations of family violence to a variety of behavioral, emotional, and functional problems.

Child Abuse and Neglect

The experience of physical abuse has been associated with aggression toward others. Children who have been sexually abused have been shown to exhibit more maladaptive sexual behavior, and children who have been psychologically abused experience low self-esteem (Briere & Runtz, 1988; Claussen & Crittenden, 1991; Copeland, 1988). Infants and young children who have been physically abused have been found to play less than comparison nonabused infants, be less focused, show less positive affect (Howard, 1986; Wasserman, Gardier, Allen, & Shilansky, 1987), and show patterns of anxious or disorganized attachment (Cicchetti, 1987; Field, 1987). Sexual incest has been linked to depression, nightmares, bed wetting, clinging, and anxiety (Oates, 1987), and neglect has been connected with emotional withdrawal and intellectual delay (Kent, 1976).

Marital/Parental Violence and Child Maltreatment

Rosenbaum and O'Leary (1981) found that 82% of the men in their study who had witnessed parental spouse abuse were also victims of child abuse. Lewis (1987) indicated that women who were physically abused by their partner in adulthood were five times more likely than a comparison group of nonabused women to report experiences of child abuse.

It has been observed that children of battered women are at an increased risk for being abused, with estimates of an overlap between spousal abuse and child abuse ranging from 30% to 60% (Hughes, 1988; O'Keefe, 1995; Suh &

from 30% to 60% (Hughes, 1988; O'Keefe, 1995; Suh & Abel, 1990). Children who were witnesses to marital violence in addition to being victims of abuse have been discovered to have the greatest behavior problems when compared to children who only witnessed violence or those with neither experience (Hughes, 1988; Kalmuss, 1984). Some of their behavior problems include conduct problems (Hershorn & Rosenbaum, 1985), adjustment difficulties (Jaffe, Wolfe, Wilson, & Zak, 1986), and aggression (O'Keefe, 1995). Increases in sleep disorders, abdominal distress, headaches and backaches, and obesity were found to be physical consequences of family violence (Browne & Finkelhor, 1986; Moeller, Bachmann, & Moeller, 1993; Rimza, & Niggermann, 1982). Children exposed to family violence have also been found to exhibit fewer interests and social activities and lower school performance (Wolfe, Zak, Wilson, & Jaffe, 1986).

Family Violence and School Behavior Problems

Violence in schools has become an increasing problem, and solutions have not been readily visible. Problems have included but are not limited to truancy, assault and battery (on other children and staff), substance use, bullying, sexual offenses, homicide and suicide, gang violence, and racially motivated violence. Many familial and environmental factors have been studied to explain or predict these school behavior problems.

Children who have been physically abused have been found to display poor school adjustment and academic performance (Garbarino, 1987; Kurtz, Gaudin, Wodarski, & Howing, 1993). Children who have been physically neglected have been reported to manifest more behavior problems and have greater school and academic difficulties than control groups (Garbarino, 1987; Reidy, 1977). Children who have been subjected to maltreatment demonstrate a higher risk of failure in school, and older children (age 14 and up) who are experiencing external problems (e.g., pregnancy, institutionalization, etc.) often end up dropping out (Kurtz et al., 1993). Trupin, Tarico, Low, Jemelka, and McClellan (1993) suggested that the cognitive and emotional sequelae of abuse contribute to severe emotional disturbances.

Zingraff, Leiter, Johnsen, and Myers (1994) found that adequate school performance was associated with a substantial reduction in the risk of delinquency among maltreated children, particularly those who suffered from parental neglect. This is one of the few studies that has looked at the relationship between child maltreatment, juvenile delinquency, and school behavior.

Violence in the Family and Juvenile Delinquency

Patterson (1982) hypothesized that the reciprocal interactive processes of child, parent, and external stress were significant in producing aggression, child abuse, and significant in producing aggression, child abuse, and delinquency. Empirical evidence from the self-reports of adolescents who are delinquents concerning prior abuse histories have resulted in rates from 21% (Alfaro, 1981) to 51% (Mouzakitis, 1981). Adolescents who had committed sexual offenses were often found to have experienced physical and sexual abuse as well as neglect (Widom & Ames, 1994). Tarter, Hegedus, Winsten, and Alterman (1984) found that 44% of the children in their study who had been abused committed violent crimes of an assaultive nature, compared with 16% of the nonabused children who were delinquents.

Scudder, Blount, Heide, and Silverman (1993) reported that students with delinquency referrals had higher rates of abuse (21.4%) than students who had no delinquency referrals (6.1%). Empirical evidence has also associated childhood abuse with teenage runaways, with percentages ranging as high as 78% (Farber, Kinast, McCoard, & Falkner, 1984). Dembo, Williams, Wothke, Schmeidler, and Brown (1992) documented that family problems and abuse/victimization experiences influence youths' initial involvement in drug use and delinquent behavior, and that once these behavior patterns were established, they tended to continue over time.

Family Violence and Adult Criminal Behavior

Dutton and Hart (1992) studied incarcerated men and found that 69% of those who had witnessed inter-parental abuse committed physical crimes and 25% of those who had witnessed inter-parental abuse committed sexual crimes. Among these incarcerated men, physical abuse in childhood was found to increase the chances for physical abuse in the family by a factor of five, and these men were twice as likely to abuse strangers or non-family members. Similarly, being a victim of child sexual abuse increased the probability of committing sexual abuse against strangers five times and within the family eight times (Dutton & Hart, 1992). Widom (1989) discovered that the adults who had been abused and neglected as children had a higher arrest rate for adult criminality and violent criminal behavior. Straus (1991) found a correlation between laws authorizing physical punishment in schools and the homicide rate.

Implications

Our society struggles to deal with problems of negative behaviors, crime, and substance abuse knowing that experiences in the early years often portend the occurrence of these behaviors in later life. Children who have experienced violence in the family have difficulty relating to others, school experiences, and standards and laws. These children exhibit inappropriate internalizing and externalizing behaviors that impede their physical and emotional development. The increase of violence in our communities has been directly associated with intra-familial factors. Research has shown the adverse impact of child maltreatment and domestic violence not only on the victims, maltreatment and domestic violence not only on the victims, but on society as a whole. The cost to the public is great, financially and psychologically. Intervention and prevention must be linked to these findings.

Although the research strongly indicates that violence in the family, particularly child abuse and neglect, is predictive of future violent behavior, the majority of abused and/or neglected children do not become violent or victims. Are there protective factors that exist in a child's life that enable that child to be resilient? Research is needed to evaluate the potential mediating variables that act to shield children exposed to violence from later dysfunctional behaviors.

While there has been an abundance of individual studies on violence in the family, and its negative effects on children have been well established, findings have been limited by the diversity of subject characteristics, definitions of variables, and measurement methods used.

Integration of these studies has also been limited. The difficulty in empirically observing families unless they are willing participants (or a part of the official records of a public agency), seems related to issues of privacy, trust or potential for criminal prosecution.

It should be recognized that it is difficult to empirically observe families, to match samples in a controlled study, to find the funding for longitudinal research, and to overcome the issues of confidentiality that impact the availability of records. Long-term consequences of childhood maltreatment have been difficult to pinpoint, particularly considering the many other mediating factors which may affect children's lives. However, the family is primary in the nurturing of mentally healthy individuals and providing a basis of knowledge for the causes, dynamics, and ameliorating factors of family violence that may impact the resolution of many of the problems faced in our society.

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A Historical Perspective on Multisystem Youth and Patterns of Institutional Care

Introduction

Much attention has been given to the complex nature of childhood and the efforts of multiple service systems in serving troubled youth. Of interest to this study were those youth with emotional disorders who were in the care of the juvenile justice system in Maryland.

A historical analysis, as a component of a research plan, was the initial step to systematically examine the interface of the Maryland Juvenile Justice Department and Mental Hygiene Administration in their efforts to provide services to youth involved with the juvenile justice system who were found to have mental disorders. This analysis contributes to the development of a framework for common understanding from which these agencies can address future issues.

Method

Data Sources

Utilization data were available through the Maryland Mental Hygiene Administration and document youth receiving institutional services by lead agency. Youth with a lead agency of either Mental Hygiene or Juvenile Justice were included (N = 1429). Computerized data of this type were limited (i.e., available from 1993 through 1995). Utilization data obtained from reports were available from 1987.

Primary archival data (in the form of photos, hospital ledgers, memorandums, and legislative reports) were obtained through the Maryland State Archives, the Johns Hopkins Medical Library Archives, the Maryland Mental Hygiene Administration, and the Maryland Department of Juvenile Justice. Secondary data sources included reference books, periodicals, and legislation listed on-line (i.e., Internet). Evaluation of the historical data judged the authenticity and content of available materials.

Analysis

A time line was constructed documenting developments from the 16th century to present day. Notation included major social events (e.g., wars and economic depressions), major legislation, and evolution of treatment philosophies over time. More recent history was highlighted by archival photos taken from the Maryland Lunacy Commission created in 1886 by the Maryland State Legislature. This Commission was directed to "visit and inspect all places public or private, where insane persons [and incorrigibles] were kept."

Patterns of institutional care were selected as indicators of the interface between the two systems because of the availability of the data and the use of institutional care throughout the long history of social efforts to control "incorrigibles."

Results

Several themes repeatedly become evident in the historical legacies of juvenile justice and mental health systems. The balance of the societal need for safety with the treatment needs of the youth are marked by advocacy and legal efforts and also influenced by the economies and public opinion of the time. As an example, the philosophical conflict between institutional approaches and more "homelike" placements was reflected in the "orphan train" movement versus development of "Houses of Refuge" in the 1870's and again a century later as efforts were made to shift care from institutional to community-based services.

Utilization patterns for both public and private facilities

Utilization patterns for both public and private facilities revealed that between 1987 and 1994 inpatient episodes decreased about 40% in the mental health sector, while increasing approximately the same amount in the juvenile justice sector (see Figure 1). Little change in admissions to private facilities has been seen over time, with slightly fewer admissions by juvenile justice (-4%) and no change in the mental health sector. For public facilities, however, admissions dropped markedly for mental health (-46%), but increased for the juvenile justice sector (+26%). Admissions by age demonstrate a marked increase in adolescent admissions for both public and private agencies (94% were 13 years or older), with a greater number of African American youth admitted to Juvenile Justice (46%) than to Mental Health (32%). The average length of stay (115 days) decreased for both the public (-4%) and private (-12%) facilities in both sectors with the greatest reduction occurring in the private sector.

Conclusion

The struggle to provide services to these multisystem youth has been a product of political-legal debate and economic compromise revolving around basic issues of humanitarian reform, security, and social order. From the development of the first juvenile court in 1899, the use of the court system to access services has contributed to the trends found. One can only conclude that the cyclical pattern of treatment versus punishment will continue as it has since history has been recorded.

We can optimize the quality of services if we were to recognize the importance of each child and family unit to the future of our society. Thinking in these terms would call upon us to join in partnerships with children and families, with our co-workers and our peers creating a system of care that balances the needs of the individual with the needs of society. As professionals we need to listen to children and families, and as advocates, we need to articulate our visions for this system of care.

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System of Care for Youth with Severe Emotional or Behavioral Disorders: A Developmental Model

Introduction

The current system of care literature identifies core values and guiding principles for developing an ideal system of care, often within a framework of a continuum of care, in terms of the degree of restrictiveness of the settings in which children and youth with severe emotional disturbance are placed (Stroul & Friedman, 1988). Friedman and Kutash (1992) have argued that one of the challenges in the child mental health field is to shift to an early intervention focus. Identifying and intervening in children's problems at earlier ages may make it possible to modestly loosen the grip that poverty and social class have on their future prospects (Schorr, 1991). Kahn and Kammerman (1992) further argued that, in theory, one of the options for designing a more powerful system of care is to emphasize the role of socialization and child developmental programs, versus treatment services.

This summary introduces a framework for conceptualizing a system of care built on a child development perspective. What is the rationale for conceptualizing and designing a system of care in this developmentally sensitive manner? First, such an approach focuses on developmental transitions which all children and youth experience. Such transitions include entry into school, negotiating the challenges associated with the teen years in modern society, and emancipation from home. In addition, these transitions, normal for many children and youth, are overlaid by additional transitional events such as divorce, remarriage, and the death of a family member. When added to routine transitions, these events pose additional adaptive burdens which place such children at risk for emotional and/or behavioral disturbance. Furthermore, the literature clearly shows that poverty is highly correlated with mental health problems for both children and adults. This cluster of factors, which this model seeks to highlight, provides insights into the dynamics by which children become at risk for severe emotional or behavioral disturbance.

Throughout the developmental stages, a system of care built around a developmental model would help identify key actors and systems of social service delivery. Beyond identifying key actors, however, it is also necessary to describe those key systems which impact most heavily on both healthy and clinically identified children and youth. For example, NACTS found that the participants in its clinical sample typically used multiple systems of care, which included schools, mental health, child welfare, corrections, and vocational rehabilitation. However, children at different periods in the developmental continuum tended to demonstrate different patterns of service system usage. For example, in the NACTS study, most children initially received service from the mental health system and schools. Later, many of these children came in contact with the child welfare system and the correctional system. Indeed, the transition that occurs when children move from status as clients in the mental health system to being relabeled criminally deviant by the correctional system warrants further analysis and policy development. This is particularly true for those children who are at high risk for coming into contact with the criminal justice system, such as clinical groups diagnosed with conduct disorder and attention deficiencies disorder. Job placement programs (e.g., vocational rehabilitation, etc.) represent a potential resource in facilitating the last transition in a child's developmental period, resulting in emancipation from one's family.

England and Cole (1992) note that service delivery should be organized to respond consistently to the ever changing needs of young clients who are growing and developing. Duchnowski and Friedman (1990) further argue that there is a need for viewing the community system as the unit of analysis in research, rather than simply looking at small components of the system. A service system organized around developmental principles addresses both of these concerns by emphasizing a community wide continuum of care conceptualized across the developmental period, from birth to twenty-two of age.

The first tier of a model for a developmentally focused system of care includes a continuum of services which focuses on those services and policies which promote the health development of our nation's children and youth. This continuum would include both health and social service providers (e.g., parental care, well baby clinics, day care, head start, schools, churches, family planning clinics, drug prevention programs, and vocational rehabilitation). These programs primarily focus on non-clinically impaired children and youth, but often include children who are at serious risk for emotional and behavioral disorders. As a result, caretakers such as parents, clergy, school personnel, day care facilities, and primary care physicians, become key actors in the lives of these children. This first level in this model performs the important function of promoting good health and mental health, while attempting to prevent serious mental health problems before they arise. Early identification and appropriate referral become crucial tasks for these actors and systems.

The second tier in this model describes the continuum of services for those children who have received clinical diagnoses. This continuum would include such programs or systems as The Early Prevention Screening and Diagnostic Treatment (EPSDT) program, special education classes, a range of mental health programs from outpatient to residential treatment programs, and programs for specific sub-populations, such as adolescents with chemical dependency and eating disorders.

Key Transitions and Implications

Early Childhood

This model, by virtue of focusing on the entire developmental period, focuses attention on early stages of development, where child mental health problems might be identified and addressed, while they may be still manageable. NACTS data indicate, for example, that child mental health problems were identified for nearly half (48.3%) of their sample children prior to entry into school (Newcomb et al., 1995), highlighting the importance of early identification and intervention. Furthermore, parents were the people most likely to first notice that a problem exists in their sample (57.2%). Pediatricians and family practitioners are also potential sources of early identification, but they have been under-utilized. Less than two percent of the children in the NACTS sample had problems first noticed by doctors. Similarly, clergy are an under-utilized resource for early identification of problems. These actors should be involved in this process at the community level through in-service trainings provided by mental health practitioners. Psychiatrists, for example, may be more viable trainers for medical personnel, with other mental health professions providing such workshops to other identified actors in the community.

School Entry

The next major developmental transition centers on entry into school, and the subsequent expansion of the child's social world, providing children both opportunities and developmental challenges. Knoff and Batsche (1990) argue that schools must be viewed, in a developmental sense, as a primary intervention environment for all children, especially for those who exhibit educational and mental health problems or concerns. One such effort at strengthening services to children and youth, within these almost universal and natural settings, is a major initiative of the Florida Department of Education to develop "full service schools" in which many mental health services are located on site in which many mental health services are located on site (Florida Mental Health Institute, 1991). Morse (1993) has provided a model of the roles schools could play in the prevention of mental health problems in children and youth.

The Teen Years

These children and youth then are required to negotiate transition from elementary schools to middle, junior, and senior high schools. At the present time in the United States, there is an alarmingly high level of interrelated negative outcomes for young people. For many teens, these outcomes include dropping out of school, substance abuse, aggressive behavior, emotional disturbance, teen pregnancy, unemployment, and criminal behavior (Florida Mental Health Institute, 1991). The increased complexity of the adolescent's social world, in combination with the multiple crises that often accompany this developmental time frame, place tremendous burdens on the multiple systems in which these children are engaged, as well as on the families and children, themselves. Thus, it is imperative that communities and families need to marshal all of the resources available to them as well as to develop new programs and strategies. A critical systems issue during this developmental period centers on the transition of many youth from receiving treatment in the mental health system to being processed through the juvenile corrections system. Over one million children and adolescents a year are processed through the juvenile courts, many of whom are children with serious emotional and/or behavioral disturbance.

Entering Adulthood

The last major transition these youth experience is the transition to adulthood. Youth with clinical diagnoses often have a particularly difficult task in moving towards independence. Unfortunately, this is an area in which these youths are typically underserved, and they under-utilize those services which are available. Indeed, Stroul and Friedman (1988) identify support for the transition to adulthood as one of their ten principles underlying an optimal system of care. They recognize that children who "age out" of the system of care become young adults who often need long-term mental health care, vocational services, and a range of other support services. Thus, it becomes important to develop functional linkages with relevant adult agencies.

Conclusion

A developmentally focused system of care would have the advantage of building on current trends in the recent paradigm shift in child and adolescent mental health and would support principles of care already described in the literature. Costello et al. (1993) note, for example, that "in the past decade, child psychiatric epidemiology has started to look at both public health and causal aspects of epidemiology from a developmental point of view."

Stroul and Friedman (1988) articulated both core values and guiding principles for an ideal system of care. This child developmental model, with its emphasis on the role of parents and its community focus, is consistent with both of their core values. Specifically, their emphasis on early identification and intervention and on a smooth transition into the adult service system as they reach maturity are issues that a developmentally focused system of care would at least attempt to address. Similarly, the National Commission on Child Welfare and Family Preservation argued that states should offer a three part system of care for children and families. The first component would involve a universal infrastructure for all families and include such services as prenatal care, parenting education, and developmental services. A strong pro active family policy would be a necessary and potentially powerful base upon which to build a functional child mental health system attuned to a developmental focus. This summary has provided a beginning framework for such a system of care.

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Assessment of Patient Functioning in a Child and Adolescent Psychiatric Facility

Authors

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Introduction

Cleo Wallace Center (CWC), like many other residential psychiatric facilities is finding third-party payers (i.e., insurance companies, departments of social services) and referral sources increasingly interested in outcome tools that measure the effectiveness of treatment. Third party payers are also seeking the least expensive care option (often translated into least restrictive care setting) for children and adolescents. In this climate, service providers must find ways to attract and retain customers and demonstrate that the services being provided are appropriate, effective, and cost-efficient.

In order to address these questions, the Child and Adolescent Functional Assessment Scale (CAFAS) was identified as the tool that would work best with our facility (Hodges, Bickman, & Kurtz 1991). The CAFAS was chosen because of it's multidimensional nature (five separate subscales and a total score), the ease of scoring, inexpensive start up costs, and understandable training materials. In addition, the scores are based on a child's observable, specific behaviors.

Method

Starting in 1994, all out-of-state patients admitted into the residential program after January 1 were scored at admission and at discharge. Scores were assigned by residential clinicians. After eight months (September, 1994), all residential clients were scored at admission and at discharge. In January, 1995, all day treatment clients were added to the list of patients to be scored. A tracking system was set up to notify residential clinicians when a CAFAS needed to be scored for a client (either at admission or at discharge). Beginning in January, 1996, all patients admitted to CWC will be assigned a CAFAS score at admission and at discharge, providing a larger sample of the 800 patients a year admitted with lengths-of-stay from 3 to 25 days.

Subjects

Admission scores were collected on 213 patients. A total of 102 of those patients also had discharge scores.

The average age for all patients with admission scores was 13.8 years, with a range from 3.4 years to 20.8 years. Eighty-eight girls and 125 boys had admission scores. Sixty-four percent of the patients with scores were Caucasian; 17% were African-American; 12% were Hispanic; and 8% were of some other ethnic background. Over half (56%) of these patients were Colorado residents. The other patients came from Nevada (13%), Pennsylvania (13%), Nebraska (10%), or other states (8%).

Patients with both CAFAS scores had an average age of 14 years. Of these, 54% were boys, and 46% were girls. A total of 69% were Caucasian; 13% were African American; 11% were Hispanic; and 7% were some other ethnic background. The average length-of-stay was 5 months, with a range from 4 days to 17 months.

Twenty-eight patients with both CAFAS scores who had lengths-of-stay under 31 days were considered separately. An updated analysis will be done on patients with short lengths-of-stay (3 to 25 days) after January 1, 1996, when implementation of the CAFAS in the hospital program begins.

Measure

The CAFAS is a multidimensional tool used to record the extent to which a youth's mental health disorder is disruptive of functioning in each of five psycho-social areas: (a) role performance, (b) thinking, (c) behavior towards others, (d) moods, and (e) substance use. For each item, a score is assigned. A total score is calculated by adding all subscale item's scores.

Two versions of the CAFAS tool were used during this study. The first version did not include subscale items for study. The first version did not include subscale items for Role Performance (school, home, community) or Moods (emotions and self harm). Moods and Role Performance scores were calculated for the 48 revised versions by taking the highest of the subscale items.

Procedures

Residential clinicians were assigned to every residential or day treatment patient at the time of admission, and were determined to be most familiar with each patient and thus best able to accurately assign individual CAFAS scores. They were responsible for therapy (i.e., individual, group, and family), treatment program planning, and working with families and caseworkers on discharge plans. Since January, 1994, 20 residential clinicians (5 men and 15 women, all with Master's level backgrounds) have assigned CAFAS scores. Ten of these residential clinicians were required to attend a two-hour training session on using the CAFAS. The other ten were hired later and received supervision in the use of the CAFAS.

Each residential clinician was required to assign a CAFAS score to patients after admission to the residential or day treatment program. The expectation was that the scores would be assigned within three weeks. Forty-six percent of the scores were assigned within three weeks. Some youth had been in the hospital program prior to transfer into the residential or day treatment program, and such patients were not assigned a CAFAS score at admission to the facility but rather when they were transferred into the residential or day treatment program. It is not currently known how long after admission to the residential program these patients were assigned a score.

At the time of discharge from the facility (or within one week), residential clinicians were expected to assign discharge scores. Only twenty-three percent of discharged patients were assigned a discharge score within one week. Sixteen percent were assigned scores within two weeks.

Analysis

Frequencies and comparison of means tests were used to analyze the 315 scores collected between January, 1994 and September, 1995. Mean scores were compared by gender and race with no statistically significant differences found. Additional means testing will be done by age, length-of-stay, state of residence, placement before and after treatment, and diagnosis for the final presentation of this study. Paired sample t-tests were used to test for significance in paired scores (admission and discharge).

Results

Initial results using the CAFAS were encouraging; patients typically had a total admission CAFAS score of over 80 indicating a need for intensive services. The total average indicating a need for intensive services. The total average score was 90.1. Figure 1 describes the average scale scores at admission for 213 patients.

Patients admitted to CWC were most likely to show disruptions in function for Role Performance (74% demonstrated severe levels of impairment), Behavior Towards Others (35% showed severe levels of impairment), or Moods (36% demonstrated severe levels of impairment). Figure 2 illustrates the percentage of patients with a severe impairment rating at admission and discharge.

Statistically significant differences were found for all subscale scores and for the total CAFAS score for 102 patients with both scores ($p < .01$). Figure 3 describes the admission and discharge scores.

Discussion

Patients admitted to CWC residential programs have an average TOTAL score on the CAFAS of 90.1 indicating a need for intensive services (i.e., the kind of services available in CWC's residential treatment program). The highest average scores were in Role Performance, Behavior Towards Others, and Moods. Patients admitted to CWC's residential program most often have mood disorders (e.g., depression, dysthymia, etc.) or behavioral disorders (e.g., ADHD, oppositional defiant disorder, impulse control disorder, etc.), which suggests face validity in describing the population being served.

Average scores show a statistically significant change at discharge, indicating that patients are improving their levels of functioning during treatment. The group of 28 patients with lengths-of-stay under 31 days also showed statistically significant changes in their scores before and after treatment in the residential program with the exception of Thinking, suggesting that the CAFAS can detect changes in levels of functioning independent of their length-of-stay.

We expect to find a relationship between length-of-stay in the inpatient program and the degree to which change is made in the levels of functioning on the CAFAS. This may allow us to describe to third party payer sources what kinds of lengths-of-stay and costs they can expect for patients with different levels of impairment. For instance, we expect to find that suicidal patients needing crises stabilization over a short length-of-stay will show marked improvement on the Moods/Self Harm scale but not necessarily any change in Behavior Towards Others. Using data from the CAFAS, we may be able to tell payers what treatment benefit (based on functional areas) they can expect to see with different lengths-of-stay. This will allow payer sources to more accurately plan for lengths-of-stay and benefits accordingly. Recidivism rates may also be affected by more effective and accurate planning based on CAFAS scores and lengths-of-stay.

Two concerns emerged through the analysis of this data. First, raters need to be more quickly prompted after admission and after discharge to assign scores. This will be addressed with the introduction of a computerized software program that allows clinicians to enter scores directly into a database with a reminder feature. This protocol is scheduled for implementation when the hospital will be added to the pool of patients being assigned CAFAS scores. Second, while inter-rater reliability appears to be acceptable, not all staff have been formally trained and inter-rater reliability tested. This will be addressed when all staff required to assign CAFAS scores will be trained in an eight-hour training program.

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Exploring the Relationship of Intensive Treatment Environments to Community-Based Care

Authors

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Introduction

The impetus toward providing community based care is a powerful driving force in the managed care revolution impacting changes in the child welfare and mental health systems. Unfortunately, there are still children who require intensive treatment environments in order for the treatment to be effective in assessing, stabilizing, and treating highly disruptive and potentially dangerous behaviors. Some researchers suggest that intensive treatment environments such as inpatient or residential are not necessary if home-based intervention is available (Stroul & Friedman, 1986; Tuma, 1989 Weithorn, 1988), and that these environments may be detrimental to the future functioning of youth (Henggeler, 1989). Others propose that inpatient treatments, particularly those with specialized treatment interventions, may be a beneficial option (Pfeiffer & Strzelecki, 1990). While intensive treatment such as residential care may be a viable treatment option for some high-risk youth (United States General Accounting Office, 1994), not enough is known about these programs to provide a clear picture of which kinds of treatment approaches work best with different subpopulations of youth with severe emotional disabilities (SED). Current understanding is limited and primarily anecdotal regarding how best to combine intensive treatment environments with home-based care alternatives to serve the most at-risk youth over time. Programs with a diverse continuum of service-intensive care that serve youth through a variety of different models and environments may be in a strong position to shed light on this question.

It is evident that intensive treatment environments can no longer be conceptualized as stand alone services; rather, they must be conceptualized and operated as part of a highly integrated continuum of care to serve high-risk youth and their families over time. This continuum of care may provide the necessary ingredients to maximize treatment effect, particularly through the interaction between wraparound services and specialized programmatic milieus. Anecdotal clinical experience and data suggest that there are still important practice issues and dynamics that need to be studied and resolved before intensive treatment milieus can be completely removed from the child mental health continuum.

Method

Specific behavioral characteristics of children in four different treatment environments were examined in order to shed light on placement decisions in relation to levels of care and severity of symptoms. Data were collected from approximately 300 total program admissions above age 5, each quarter, for an 18 month period of time. Each child's scores on the Devereux Scales of Mental Disorders (DSMD: Naglieri, LeBuffe, & Preiffer, 1994) were averaged by scale, composite, and total score reflecting their behavior throughout the specified level of placement. The children were in four different treatment environments at Beech Brook, a child mental health agency. The four programs included: an intensive pre-adolescent age residential treatment program; a pre-adolescent age day treatment program; an urban (Cleveland Public Schools) pre-adolescent age school based mental health program for children with severe behavioral handicaps (SBH); and a treatment foster care program. The sample included 90 children in residential treatment, 51 children in a day treatment/partial hospitalization program, 24 children in an urban school-based mental health treatment program, and a total of 166 pre-adolescent and adolescent youngsters in a treatment foster care program. Of this sample of 331 children, 61% were male, 39% female, and 74% were African-American (see Table 1). The primary focus of this investigation was to determine if the type and severity of child behavioral characteristics as measured by a standardized behavioral rating instrument accurately discriminated children in different intensive treatment environments. A secondary focus of this investigation was to explore whether these findings could help identify clinical and practice issues inherent in treating the most "deep-end" youth, many of whom have had access to an array of community wraparound service options.

The DSMD is a 110-item (or 111-item for the adolescent version) behavior rating scale designed to evaluate behaviors related to psychopathology in children and adolescents. There are two separate instruments, with comparable items and subscales&endash;one for children ages 5 - 12 and the other for children ages 13 - 18. The instrument has three composite scores (externalizing, internalizing, and critical pathology) and each is made up of two subscales (conduct and attention [or delinquency for adolescents], depression and anxiety, acute problems and autism). An overall total test T-score is also included. The DSMD total and composite scales have excellent internal reliability (Cronbach's alpha of .97 for Total Scale score) reliability (Cronbach's alpha of .97 for Total Scale score) and test-retest reliability. Also, there is good interrater reliability with a clinical population (Cronbach's alpha of .52 for Total Scale score). The DSMD is well suited for use in evaluating mental health treatment outcome reflecting the full range of psychopathology, including the more severely disturbed behaviors that are often missing from other rating scales. A total test T-score of 60 has been empirically determined to be the best cut-score for differentiating clinical from non-clinical samples.

Results

Preliminary analyses focused on examining comparisons among youth between four different levels of care. Univariate Analyses of Variance (ANOVAs) tests were performed for the six scale, three composite, and total scale DSMD scores. If the ANOVA was found to be significant ($p < .05$), post-hoc Bonferroni tests were performed to identify where the differences between levels of care resided.

The DSMD mean T-scores for children in residential care were consistently greater than for subjects in other levels of care (see Figure 1) and reliably discriminated children in residential care versus treatment foster care on four subscales (acute, anxiety, depression, and conduct), two composite scales (internalizing and critical pathology), and the total scale T-score (see Table 2). The sequencing of the discrimination of children followed the expected direction with children in the most intensive treatment environments having higher scores (indicative of greater dysfunction) and the children in the less intensive treatment environments having lower scores. The DSMD further identified specific problem domains (e.g., depression) related to the most high-risk youth placed in residential treatment. On the average, these youngsters (both male and female) tended to be significantly more depressed than their counterparts in day treatment and foster care. Depression, however, is not the reason that pre-adolescent children are referred to the most intensive treatment environments. It is typically for more acute behaviors and the failure of intensive community-based models to safely manage these behaviors.

Perhaps the most concerning findings were that the youngest children in residential care (i.e., 9 years of age or less) were, overall, the most clinically disturbed across DSMD measures, and as a group had experienced the highest rate of previous placement moves. Independent t-tests yielded statistically significant differences on all DSMD scales (except conduct and anxiety) between the younger residential children (age 9 or less) versus the older residential children (ages 10 - 13; see Table 3). This subgroup (i.e., ages 5 - 9) contains some of the "youngest and the deepest" children in Ohio's child welfare and mental health system for whom previous community treatment has been a series of disrupted placement failures. As a whole, this group appears to be poorly understood, highly under this group appears to be poorly understood, highly under serviced, and systematically targeted for less intensive treatment options.

Discussion and Implications

The implications of this exploratory study are both practical and theoretical. Practical implications from this study suggest that children in different levels of intensive care (i.e., residential and treatment foster care) can be distinguished by the severity of their behavioral characteristics. It would also appear that some of the "youngest and the deepest" of these children may be at the highest risk for having treatment needs neglected or delayed until they have experienced numerous treatment failures or dangerous levels of symptom severity. While the purpose of this investigation was to identify characteristics of the role that intensive treatment environments may play in continuums of community-based care, controlled studies are needed to determine the relative efficacy of these programs compared to alternative treatment models. Caution needs to be exercised, however, in randomly assigning children with the most severe disturbances due to four issues: safety concerns, the high number of previous treatment failures, the consequences of continued placement failures, and the impact of the subjects' deteriorating clinical course.

Theoretical implications point to the utility of blending wraparound and intensive programmatic models of service to reduce disruptions, stabilize and support placements, and effectively treat youth with chronic, severe impairments. The differential management and treatment of these children requires a broad range of specialized intervention options addressing varying levels of impairment and need that are not quickly or easily remedied. The tendency to separate wraparound models of intervention from programmatic models with highly individualized and specialized services dichotomizes complex treatment realities and distorts the development of best clinical practice protocols. The next generation of treatment paradigms for youth with severe emotional disabilities will blend the flexibility of wraparound services with the episodic intensity of specialized clinical paths and programs.

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The Characteristics of Repeat Offenders Referred for Mental Health Evaluation in the Juvenile Justice System

Authors

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Introduction

The recidivism of delinquent youth and characteristics of these repeat offenders have been the subject of several investigations. Among the characteristics that have been found to be correlated with repeat offending have been attachment to parents, parental supervision, alcohol and drug use, and past criminality (Loeber & Stouthamer-Loeber, 1986), in addition to the demographic characteristics. However, the variables in most of these studies have generally been limited to a few demographic variables such as age, ethnicity, and gender.

Although there is considerable information in the literature on the characteristics of youth detained in correctional facilities who are repeat offenders, there is little information in the literature youth with mental illness who are repeat offenders. It is unclear from the literature whether the detainment of youth with mental illness is related to demographic, clinical, or service use characteristics. Multiple investigators have found that minority youth tend to be incarcerated at a higher rate than white youth (Eisenman & Kritsonis, 1993; Brown, Rhodes, Miller, & Jenkins, 1990). This trend appears to remain constant for youth with mentally illness (Lewis, Shanok, Cohen, Kligfeld, & Frisone, 1980; Cohen et al, 1990).

Despite the fact that there have been few studies which examine the effect of gender on detention, gender bias also appears to exist. Males tend to be incarcerated at a higher rate and commit more serious offenses than females. Females, however, are more likely to be arrested for status offenses than males (Dembo, Williams, & Schmeidler, 1993). Female detainees also have an elevated degree of deprivation and neglect at home (Chesney-Lind & Shelden, 1992).

It has been estimated that as many as 60% of youths detained in juvenile corrections facilities suffer from emotional disorders (Cocozza, 1991). Youth detained in corrections facilities have been found to have levels of psychopathology similar to the levels of mental illness found in psychiatric hospitals (Davis, Bean, Schumacher, & Stringer, 1991; Pumariega, in press). Despite these findings, most U.S. juvenile detention facilities do not have an adequate screening procedure for detecting emotional disturbance among its detainees (Barton, 1976). The emotional difficulties experienced by these youth are likely to receive little professional attention by mental health practitioners prior to incarceration. This is a trend that is likely to continue once the youth is detained due to the paucity of mental health services that are provided in most juvenile justice settings (Anno, 1984).

Furthermore, the decision of whether to provide treatment or not is usually based on the conclusion of an individual staff member who may not have a theoretical basis for judgement (Barton, 1976). Many of these individuals have the same biases about juvenile crime and delinquency as the general population. Because of ethnic, gender, and anti-mental health biases, there may be little or no thought given to mental illness and how that illness might have contributed to the behaviors that have been exhibited by the youth. Additionally, many of the individuals making the decision to detain or refer the youth for mental health evaluation have numerous organizational pressures and constraints that might prevent them from referring the youth for mental health services even when the need is felt to exist (Mulvey & Reppucci, 1984).

To date, few studies have examined the difference in characteristics between first time and repeat offenders with mental illness. In this study, we examined demographic, clinical, and criminal history and their relationship to whether the youth was a repeat or first time offender in a sample of youth referred for mental health services at a juvenile corrections facility. The hypotheses that we explored in this study were: (a) Demographic variables are a greater predictor of repeat offending than clinical variables; and (b) youth with a history of violent offenses are more likely to be repeat offenders than youth with a history of non-violent offenses.

Setting

The San Fernando Valley Juvenile Hall (SFVJH) is one of three juvenile halls that serve Los Angeles County, California. The juvenile halls each house both pre-adjudicated as well as post-adjudicated youth. The facility has a mental health treatment center located on site which provides mental health services to approximately 500 youth each year. The entire facility has an average daily census of 600 youth, and approximately 3200 youth are detained annually.

The youth can be referred for mental health evaluation by either (a) nursing staff upon intake, (b) detention staff members who work directly with youth in one of 10 housing units, (c) teachers who teach at the school located on the grounds of the juvenile hall, (d) the probation officer who worked with the youth prior to detention, or (e) the parents who could contact the mental health staff directly. There is no formal mental health evaluation either at the time of intake or at any time during the youth's stay in juvenile hall.

Subjects

The subject population (N = 244) was assembled from 244 consecutive referrals during a six month period (January 1-June 30). All youth were between 12 and 18 years of age.

Methods

This study involved reviewing the mental health and probation records of the youth. The probation department's master files were explored for data on all youth in the juvenile hall during the period of the study (N = 3,283). Only aggregate data was available on the non-referred youth; individual level data was not available. The items available from the probation department chart review included the current offense, age at first arrest, and the total number of detentions. The items that were available from the mental health department record review included the following: (a) the current age of the youth; (b) history of previous mental health treatment; (c) drug and alcohol use history; (d) mental health diagnoses; and (e) reason for mental health referral, which was classified as either an internalizing or externalizing behavior based on the narrative provided by the referrer.

The offense precipitating the youth's current incarceration, or "current offense," was categorized by the level of violence. If the youth engaged in a behavior in which physical force or the threat of force was used against another individual, or a weapon was used in the commission of the crime, the youth was classified as being a violent offender. For our sample of youth, violent offenses consisted of murder, attempted murder, rape and sexual assaults, assault with a deadly weapon, assault and battery, and robbery (if a weapon was used). Recidivism rate differences in gender, race, age, mental health service use, drug use internalizing behavior, years of delinquency, and whether the current offense was a violent offense were explored using a logistic regression model. Chi-square and t-tests were used to compare the total juvenile hall population with our sample of youth.

Results

The population of 244 patients included 144 (59%) first time offenders and 100 (41%) repeat offenders. Our sample time offenders and 100 (41%) repeat offenders. Our sample of referred youth is compared with the total population of youth in Table 1. The referred youth represented 7.4% of the population at the juvenile hall. Of the referred youth, 40% had previously received mental health treatment. Those referred for mental health evaluation differed significantly from youth in the general population of youth in juvenile hall. Females, non-Hispanic youth, and violent youth were over-represented, while Hispanic youth and first time offenders were under-represented in our sample.

Among the referred sample, 123 (50%) of the youth reported the current use of alcohol and/or drugs. Among those who used drugs, 90% reported current use of two or more drugs. The drugs most often identified were alcohol, marijuana, crack cocaine, methamphetamine, and hallucinogens.

Table 2 shows the results of the logistic regression. Among referred youth, the juvenile justice history variables were more associated with recidivism than clinical or demographic variables. Age at first offense was most strongly associated with recidivism, whereas violent offenders were half as likely to be repeat offenders. Minority youth were twice as likely to be repeat offenders than non-minority youth, and youth referred for internalizing behaviors were twice as likely to be repeat offenders. The previous use of mental health services had no affect on recidivism.

Discussion

The referred youth in our sample differed significantly from youth in the overall population at the juvenile hall in almost all categories measured. The sample included fewer first-time offenders and Hispanics; it included more females and more youth with a history of serious violent offenses. It is likely that these findings reflect referral bias: the juvenile hall staff may have been more likely to refer certain "types" of youth for mental health services.

Conversely, the results of this study suggest that the arrest patterns for youth referred for mental health services are more likely to be affected by the juvenile justice history of the youth than by clinical factors, including drug use and previous mental health service use. The number of years of delinquency appeared to be the strongest predictor of repeat offending within the group of referred youth. These results are consistent with those which show early age of onset of offending to be strongly correlated with recidivism in non-clinical populations (Lattimore, 1994; Tolan, 1995). Thus, the treatment modalities that are used with juvenile offenders who have emotional disturbances must include treatments which focus on the youths' delinquent behavior as well as the clinical symptoms which are non-criminal in nature.

There was a trend that violent offenders were half as likely to be repeat offenders as non-violent offenders, although this did not reach statistical significance ($p = .05$). This finding was unexpected, since literature supports the fact that youth tend to start out with low level crimes that escalate to more serious offenses, and therefore, repeat offenders would be more likely to be violent offenders than first time offenders. The youth in this study tended to commit a single violent offense that caused them to be detained for a longer period of time compared to other studies where youth committed several violent offenses before committing a serious violent offense. It is possible that these youth differ in some way from other youth, or they are perceived by staff members in a way that would cause them to have different referral patterns from other detained youth.

This study has several limitations including a lack of objective clinical information on each of the youth (e.g., the type and amount of previous services used, family history data, and information on staff attitudes about the youth which could significantly alter referral patterns). Despite these limitations, this study suggest that a component of the treatment of youth with mental illness who are at risk for detention in the juvenile justice system should address violence and its potential impact on youth. Additionally, a special effort must be undertaken to determine the needs of ethnic minorities, especially Hispanics, who are grossly underrepresented among the referred youth.

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Essential Elements of Child Protection Mediation

Introduction

The rapid growth of mediation in fields as diverse as divorce mediation and commercial dispute resolution has raised the interest of a growing number of child welfare service providers and scholars interested in finding a more constructive process for developing collaborative service plans with families and youth (Mayer, 1987). Several jurisdictions have already introduced mediators at various levels of the child protection system (Barsky, 1995a; Thoennes, 1994; Savoury, Beals, & Parks, 1995). Mediation is proposed by some advocates as a more effective method for engaging families in treatment (Bernstein, Campbell, & Sookraj, 1993). Others argue that it could produce major time and cost savings by avoiding protracted court hearings (Morden, 1989). Yet others maintain that mediation provides a basis for empowering families and ensuring that child protection services proceed in a manner that is least intrusive to families and children (Regehr, 1994; Wildgoose, 1987).

Most writings to date have focused either on developing a rationale for using mediation in child protection (Eddy, 1992; Palmer, 1989) or on evaluation of various programs (Campbell & Rodenburgh, 1994; Centre for Policy Research, 1992; Wildgoose & Maresca, 1994). However, there has been insufficient work describing the process of child protection (CP) mediation, and analyzing ways in which mediation can be integrated into child protection services. Accordingly, this study was designed to provide an in depth understanding of the process of mediation in child protection, and to identify the essential aspects which may contribute to developing more effective working relationships with child welfare families. This study focuses on neutrality, one of the primary aspects of CP mediation identified by the research participants. This study is distinct from prior studies because it entails the use of extensive interviews with family members, as well as with professionals involved in mediation and other CP processes.

An analysis of their experiences contributes to the child welfare and mediation literature: (a) by beginning to determine the critical experiences of parties involved in the different processes, (b) by developing a framework delineating the essential aspects of the mediation process that are unique to mediation, and (c) by identifying mediative skills and strategies that can be employed in other areas of child protection services.

Methods

In order to develop a better understanding of the dynamics of child protection mediation, this study used naturalistic inquiry methods (Denzin & Lincoln, 1994). The author conducted a series of exploratory "long interviews" (McCracken, 1988) with 17 adult family members, mediators, and child protection workers (CPWs) who had been directly involved in five mediation cases. The primary strategy of these interviews was to have research participants discuss what they felt were the critical issues in their experiences with mediation. Six pre-mediation interviews, and six additional interviews were also conducted with family members and CPWs from three non-mediation comparison cases. The author asked participants in these interviews to describe their experiences with CP interventions, including investigations, social casework, case conferencing, solution focused therapy, and child protection court. The experiences of the research participants in the pre-mediation interviews and in the non-mediation cases provided the contrast points used in identifying the essential aspects of mediation (Spradley, 1979).

Mediation cases were sampled on the basis of availability and willingness to participate from a pool of approximately 30 mediation cases seen by the Center for Child and Family Mediation in Toronto. The Centre offers mediation to Toronto families who are involved in the child protection system. In terms of demographics of research participants, most families involved in both the mediation and non-mediation cases were headed by a single mother who was either receiving government assistance or earning less than $30,000.00 annually. All but one family had either one or two children. These demographics are consistent with the general population of families involved in child protection mediation in Toronto.

The sample of non-mediated cases was drawn purposefully on a case-by-case basis by having CPWs from the mediation sample identify matching cases from their own caseload. Selection was done to ensure that the comparison cases matched the mediation cases in terms of demographic profiles, type and severity of maltreatment, placement status, and level of involvement by participants in the case planning process. In terms of ethnicity, families in the mediation sample included people from European, African, and mixed Euro-African backgrounds. All of the families in the non-mediation sample came from Euro-Canadian the non-mediation sample came from Euro-Canadian backgrounds. Matching for ethnicity was not prioritized, because both mediators and child protection workers suggested that the most important factor to consider was the type of intervention used in the non-mediation cases. Therefore, the investigator tried to select comparison cases in which mediation-like interventions were employed.

The interviews were audio-taped and transcribed. In a situation where a parent asked not to be taped, written notes were used to develop a transcript. Each interview was read, re-read and analyzed as it was completed, rather than waiting to analyze all of the interviews together. Key themes and patterns from the interviewees' perspectives were identified from the transcripts (Lincoln & Guba, 1985; Taylor & Bogden, 1984). The interview guides were altered for subsequent interviews in order to further explore important topics and perspectives raised by interviewees that had not originally been identified by the researcher. McCracken's five-stage model for data analysis was employed (McCracken, 1988). The transcribed texts were processed for analysis with the Ethnograph (Seidel & Clark, 1984) computer software package. Lincoln & Guba's (1985) method for establishing trustworthiness was used throughout the study. "Credibility," "transferability," "dependability," and "confirmability" (the qualitative research equivalents of internal validity, external validity, reliability and objectivity) were each considered.

Results

During the initial stage of analysis, the researcher attempted to identify as many themes as the participants' data indicated. This effort resulted in a broad base of 92 themes. Many of these themes overlapped, and some of them did not prove to be significant in later analysis. However, since the purpose of the study was to look at mediation from the participants' perspectives, it was beneficial to start with a broad identification of themes. The initial themes were loosely categorized into nine pools (Barsky, 1995a): 1) Intentions and Concerns of the Parties; 2) Mediation Interventions; 3) Dynamics between the Parties; 4) Appropriateness for Mediation; 5) Comparisons made by the Parties; 6) Roles of the Parties; 7) Factors Affecting Decisions; 8) Outcomes; and 9) Impact of the Research.

In the next stage of analysis, ten essential elements of the mediation process were identified. These elements were derived in part from the aspects of mediation that mediation participants identified as being most important. There were also certain recurring elements that the parties did not specifically identify as most important, but which emerged implicitly as defining features of their experiences in the mediation process. One of the difficulties in this process was isolating elements that the interviewer may have suggested through the use of leading questions. For this purpose, it was useful to look at the early portions of the interview where the interviewer asked more general

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interview where the interviewer asked more general questions. Eventually, ten distinct essential elements were identified: 1) alliance, 2) bringing parties together, 3) facilitating communication, 4) keeping peace, 5) developing options, 6) enhancing understanding, 7) focusing the parties, 8) contracting, 9) neutrality, and 10) fairness. Comparisons with non-mediation cases suggested that many of these elements, though essential to mediation, were not necessarily unique. CPWs involved in case conferencing and solution-focused intervention utilized techniques similar to those used by mediators. However, mediator neutrality was found to be unique to CP mediation.

Discussion

Child protection mediation is a peculiar use of mediation, given that one of the clients is a professional who traditionally assumes a mediation role in his/her own work. When suspicions of child abuse or neglect are brought to the attention of a child protection agency, the assigned worker is mandated to investigate and intervene in order to ensure that the child is not at risk. In the context of child protection, a worker could mediate between disputing family members about how they will share responsibility for a child's needs. Similarly, a worker could mediate between parents and foster parents about how and when the parents will spend time with the child. But is a child protection worker truly able to function as a neutral third party? For CP mediation to have value as a distinct intervention, it needs to be defined in a way that is different from just "good clinical practice" by CPWs. Otherwise, a CPW could fulfill the role, making the use of an independent mediator redundant (Barsky, 1995b). One of the major findings from the present research was that neutrality does differentiate the role of a mediator from the role of a CPW.

Although the present research was not intended to evaluate the effectiveness of CP mediation, research participants tended to volunteer positive feedback on their experiences in mediation. In particular, informants reported that mediation helped them to resolve issues without going to court, helped build a more positive relationship between family members and the agency, and gave all parties a sense of being heard and treated fairly. CP mediation is not a panacea, as noted by the frustration of some parties in cases that did not settle. However, given the efficacy of mediation in this small sample of cases, further study is warranted.

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Service Use Patterns of Children with Depressive and/or Disruptive Disorders: Findings from the MECA Community Sample

Authors

Introduction Method Results Discussion References

Introduction

Many studies have shown that only a small proportion of youth with psychiatric problems receive professional help (Burns, 1991), and that youth with depressive or anxiety disorder are less likely to be referred for services than youth with disruptive disorder (Anderson, Williams, McGee, & Silva, 1987; Cohen, Kasen, Brook, & Struening, 1991). However, few studies have examined the service use patterns of children with depressive disorder in community samples. This study addresses two questions:

1. How likely are children with depressive disorders to use mental health services?
2. Are the patterns of service use and parents' perception of service use barriers the same for children with depressive disorder as for those with disruptive disorder?

Method

Sample and Data

Data were derived from a multi-site community survey conducted in 1992 and funded by NIMH: the Methods for the Epidemiology of Child and Adolescent Mental Disorders (MECA) Study (Lahey et al, in press). This probability sample consists of 1285 child (ages 9-17) and parent/guardian pairs, and was drawn from four geographic areas: (a) Hamden, East Haven and West Haven, Connecticut (N = 314); (b) DeKalb, Rockdale, and Henry Counties, Georgia (N = 299); (c) Westchester County, New York (N = 360); and (d) San Juan, Puerto Rico (N = 312).

Structured, in-person interviews were conducted to obtain psychiatric diagnoses, as measured by NIMH's Diagnostic Interview Schedule for Children (DISC), version 2.3 (Shaffer, et al., in press), and impairment, measured by both the Non-Clinician Global Assessment Scale for Children (Bird, submitted) and the Columbia Impairment Scale (Bird et al., 1993). The Service Utilization and Risk Factors (SURF) interview was also administered (Leaf et al., in press).

Measures of Depressive and Disruptive Disorders

- ***Depressive disorder (parent or child report):*** Meets DISC criteria for major depressive disorder and/or dysthymic disorder, is positive on diagnosis-specific impairment (as measured by the DISC), and has a CGAS score (interviewer assessment) lower than or equal to 70.
- ***Disruptive disorder (parent or child report):*** Meets DISC criteria for attention deficit hyperactivity disorder, oppositional defiant disorder, or conduct disorder, is positive on diagnosis-specific impairment (as measured by the DISC), and has a CGAS score (interviewer assessment) lower than or equal to 70.

Measures of Service Utilization and Barriers to Services

- ***Ever used any service (parent or child report):*** Child has ever used any of the following services for emotional or behavior problems, or for the use of alcohol or drugs (Leaf et al, in press): (1) mental health specialist (see below for details); (2) medical professionals; (3) school-based services; (4) social services; (5) clergy; and (6) other (e.g., spiritualists, herbalists).
- ***Ever used any mental health specialist (parent report):*** Child has ever seen any of the following: (1) psychiatrist, (2) psychologist, (3) counselor, or (4) social workers.
- ***Ever used two or more non-school mental health services (parent report):*** Ever used two or more types of non-school mental health services with one of them being a mental health specialist.

being a mental health specialist.

- ***Parent's perceived barriers:*** Barriers to the use of child mental health services are measured by parental report of the number of barriers to service, based on 17 questions relating to the cost of treatment, access to services, and knowledge of and attitudes towards mental health services.

Results

In the MECA sample, 176 children (13.7%) met diagnostic criteria for either depressive or disruptive disorders (Shaffer, et al., in press). Among them, 44 children were diagnosed with depressive disorder only, 96 children with disruptive behaviors only, and 36 children met the criteria for both depressive and disruptive disorders.

Service use patterns were first compared for children with depressive disorder only, disruptive disorder only, both disorders, and neither of the two disorders. To further test the hypothesis that children with depressive disorder use less service than children with disruptive disorder, the disruptive disorder only group and the group with both disorders were combined into a "Disruptive disorder" group.

Children with either one or both disorders used more services than those with neither of the disorders. For children with depressive disorder, 61.4% have used any service; only 34.1% have ever seen a mental health specialist, and only 25.0% have ever used 2 or more non-school mental health services. Children with disruptive disorder, regardless of having depressive disorder or not, are more likely to use service than children with depressive disorder only. The difference is statistically significant for seeing a mental health specialist (see Table 1).

Three barriers were found to differ significantly between children with depressive disorder only and children in other groups. More parents of children with depressive disorder only reported that mental health professionals were unfriendly and that they did not trust mental health professionals than did parents of children with disruptive disorders or neither of the two disorders. Also, more parents of children with depressive disorder only reported that they were unable to get an appointment (see Table 2).

Logistic regression analyses of lifetime service use were conducted for the total sample in five steps (5 models). In each model, study site, mother's education, family income, health insurance, parental psychopathology, child's age, sex, ethnicity, and number of lifetime chronic illnesses were controlled. In addition to these control variables, depressive disorder was entered in Model 1; disruptive disorder was entered in Model 2; both depressive and disruptive disorders were entered in Model 3. Model 4 included all the variables in Model 3 as well as parent and child ratings on the Columbia Impairment Scale (i.e., CIS score of 16 or more). Model 5 included all the variables in Model 4 as well as

Model 5 included all the variables in Model 4 as well as parent perception of child service need.

When depressive disorder and disruptive disorder were entered into the logistic regression separately to predict lifetime service use, the Adjusted Odds Ratios (AOR) for disruptive disorder (Model 2) for all three service use variables were much higher than those for depressive disorder (Model 1). This pattern also held when the depressive and disruptive disorders were entered into the equation simultaneously (Model 3). When the parent and child ratings of child impairment (CIS) and parent perceived need were entered into the equation (Model 4 and 5), the effects of depressive disorder became non-significant, while the effects of disruptive disorder still held (see Table 3).

Discussion

Consistent with other studies (Anderson et al, 1987; Cohen et al, 1991), the findings here show that children with depressive disorder are less likely to use services than children with disruptive disorder. Also, parents of children with depressive disorder report more barriers to service than children with disruptive disorder. These findings suggest that children with depressive disorders are less likely to be identified or referred to mental health services, and that they have more difficulties in accessing services.

Parent's perception of the child's impairment and need for service use plays an important role in the child obtaining mental health services. This finding may be related to the lack of service use by children with depressive disorder, as this and other internalizing disorders are less likely to be recognized by other people, including the parents.

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Chapter 9

School-Based Models

Michael Stayed in the General Education Classroom

Introduction

Best Practices (Best Practices for Educating Students with Serious Emotional Disturbance in Their Local Public Schools and Communities) was a three year grant funded by the US Office of Education and Rehabilitative Services. The purpose of the grant was to use best practices in the development of programs and services for students with serious emotional disturbance (SED) and their families, so that the students could remain at their local public schools, or plans could be developed so that the students could return from alternative placements. The grant was a collaborative effort between local Vermont schools, the University Affiliated Program of Vermont (UAP), the Vermont Interdisciplinary Team for Intensive Special Education (State I-Team), and the Vermont State Department of Education, Division of Instructional Support Services. Mechanisms with local and state Departments of Education, Mental Health, and Social Services were developed to facilitate the model programs.

The model programs and support services that were developed through involvement of the Best Practices project focused on parent and student centered services, family-school collaboration, collaborative teaming, classroom accommodations, peer support, instructional support services, teaching prosocial skills, interagency involvement, behavior management, and transition planning.

Method

Subjects and Sites

A total of twenty-seven schools in twenty-two different school districts across Vermont participated as sites in this project. All the sites had students with serious emotional disturbance as defined by the Federal Educational definition of severe disabilities and serious emotional disturbance (P.L. 100-476 of 1990), or Vermont's Act 264 definition of severe emotional disturbance (Vermont Act 264 of 1988).

The school sites chosen for participation in the project met the following criteria: (a) administrative commitment at the building level for educating students with serious emotional disturbance within the regular education environment; (b) willingness to establish a "school-wide planning" process to assist in developing plans for implementing best practices for all students (Fox & Williams, 1991);

(c) on-site case manager for each student with serious emotional disturbance involved in the project; (d) commitment from school administration and school staff to in-service training and participation in the project; (e) commitment to provide school based family support services and to involve parents in all aspects of students' programs; (f) commitment to communicate with and involve local mental health and social service agencies to support each student's program needs; and (g) willingness to use an individual student support team process (Hamilton, Welkowitz, Mandeville, Prue, & Fox, 1995) to assist in developing and implementing educational activities for at least one student with or at risk of serious emotional disturbance.

The thirty-six participating students with SED, in grades K through 12, were either at risk of removal from their educational setting or were returning to their regular educational setting from a more restrictive placement.

Intervention

An individualized approach to each student and school participating in this project was emphasized. A school planning team was formed at each school site. The school planning teams involved administrators, school board members, parents, regular educators, and special educators, a member of the school's instructional support team, other community mental health and social service agencies, and local community members. One focus of the school planning team was to examine existing educational practices and to recommend changes and improvements which would enhance the education of all students. Additional activities included: (a) identifying resources which were available to the school; (b) determining the availability of best practices for students; (c) identifying support needs of students, families, and staff; (d) identifying needed changes in school policy and service related delivery; and (e) developing an policy and service related delivery; and (e) developing an action plan for attainment of one goal as determined by the school planning team.

Individual student planning teams were formed around each child and their family. Members of these teams attended a Fall Institute which focused on using a functional assessment process (Hamilton et al., 1995) to determine areas of need for the student, identifying and making educational accommodations, and using a problem solving process to identify prevention, teaching, and response strategies for problematic behaviors by the student. Each individual student planning team typically included the student's parent(s), classroom teacher, special educator, guidance counselor, a member of the school's instructional support team, and the school principal. Extended Team members included the State I-Team regional consultant, representatives from mental health, social services, and other relevant community agencies.

The purpose of the student's planning team was to support and assist the teacher in developing and implementing the student's educational activities, to provide a vehicle for home-school communication and support, and to develop transition plans between grade levels, schools, and into adulthood. Typical activities of the student planning team involved: (a) identifying training and information needs; (b) developing long-range educational plans for the student; (c) adapting and accommodating regular education activities; (d) problem solving and implementing strategies for problematic behavior; and (e) accessing mental health and social services agencies for needed services.

Evaluation

The project used quantitative and qualitative methodology to evaluate outcomes. Semi-structured interviews were conducted at the beginning and end of each school year with the students with SED, their peers, their parents, and their regular and special education teachers.

Surveys and questionnaires were completed at the beginning and end of each school year by the student's family, his or her peers' families, the student's administrator, and regular and special educator. Members of the students' individual support teams completed a survey in regard to their teaming process and their success in addressing the needs of students with SED. T-test analyses were conducted for each question to determine whether the participant's response prior to participation in the project was significantly different from their response following participation, support, and training.

A behavior checklist was also completed at the beginning of the school year and at the end of the school year by: (a) the student, if eleven years old or older, using the Youth Self Report (YSR; Achenbach, 1991b); (b) his or her teachers, using the Teacher's Report Form (TRF; Achenbach, 1991a); and (c) his or her parents, using the Child Behavior and (c) his or her parents, using the Child Behavior Checklist (CBCL; Achenbach, 1991). T-test analyses were conducted to determine whether the scores were significantly different for each of these measures following training, support, and participation in the project.

Results

This project involved thirty-six students with SED who were in grades K through 12 in twenty-seven schools in twenty-two different school districts, their respective families, educational and related service providers, community based service providers, and communities. All but two of these students were successfully educated within the regular education classroom in their local public school.

Surveys and Checklists

There were no statistically significant differences in how the classmates' families (N = 174) responded to the Family Survey questions (see Table 1), or for the administrators' responses (N = 13) on the Admin-istrator's Survey (see Table 2), between the first and second administration. Overall, their responses were neutral in regard to any of the given statements.

There were several statistically significant differences for the teachers' responses (N = 30) between the first and second administration (see Table 3) of the General Education Teacher Survey and Special Education Teacher Survey, and in how team members (N = 118) responded between administrations of the Individual Student Planning Team Survey (see Table 4).

There were no statistically significant differences between the pre- and post-administrations of the CBCL, YSR, and TRF. The students with SED continued to be perceived by others and themselves as having behaviors within the clinical range following participation in the project.

Semi-Structured Interviews

The students did not specifically attribute their experiences to being in inclusive classrooms; however, three themes did emerge from the data that were related to going to school with typical peers. These included how students solve problems, how students cope with challenging situations, and a student's desire to help others.

All of the educators were asked what effect inclusion had on them professionally and personally. Their responses focused on: (a) quality of education for the student; (b) awareness of individual student differences and needs; (c) awareness of the needs of all students; (d) patience, workload and stress; and (e) style of teaching. When the responses from the two interview sessions with each teacher were compared, it was found that the educators' perceptions did not change. For example, if their perceptions were initially negative in example, if their perceptions were initially negative in regard to inclusion of students with serious emotional disturbance in the regular classroom, they remained negative, despite the student's program being successful overall.

With the exception of one participant, the special educators in this study felt that inclusion had made a positive impact on their professional and personal lives. One of the primary benefits was that the educators felt they were able to work as a team to serve these students.

With respect to parents' involvement in the team process, the results indicated that parents varied in the degree to which they felt like a full team member with an equal voice in decision-making. On one end of the continuum were parents who expressed minimal involvement with the teams, and at the other extreme were parents who indicated that they were "most definitely" full team members, with equal say in all decisions regarding their children.

Discussion

Students with SED are often viewed as the one group of students receiving special education services who cannot be successfully included within the regular classroom environment in their local public schools. Few studies, however, have been done in schools which fully include these students in the regular classroom.

In the Best Practices Project, the development and implementation of educational strategies which emphasized prevention and the teaching of replacement skills allowed almost all of the participating students to continue to receive their educational services within the regular education classrooms. The findings from the project evaluation suggest that with adequate school-wide planning and access to training, and use of an individual student support planning team process, peers, parents, administrators, special educators, and regular educators are willing to have students with SED within the regular classroom in their local public school.

Based on these initial findings, the above study is now being extended to include up to forty rural school sites across the nation. It is expected that participation as a site will lead to supportive and proactive interagency planning and inclusion of children and youth with SED in their general education classroom in their local public school in other rural states.

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Onward to Outcomes in the School of the Future

Introduction

In conjunction with the school reform and children's mental health movements, the concept of full service schools has received considerable attention in the last few years (Dryfoos, 1994). At the same time, increasing attention has been given to the need for outcome measures of effectiveness across the spectrum of health and human services. This summary reports on efforts to conduct longitudinal research to assess the efficacy of a comprehensive school-based service program in Texas, the School of the Future project.

The School of the Future, funded by the Hogg Foundation for Mental Health, was a five year demonstration project in four Texas cities: Austin, Dallas, Houston, and San Antonio. Each site received a grant of $50,000 per year for five years to develop and coordinate health and social services through targeted schools in low income, predominantly ethnic minority locales. Services were provided for children from pre-natal care through age 15, and their families. The grant essentially provided salary and benefits for one full time position, the Project Coordinator, with a small operating budget. The grant was intentionally small enough that direct purchase of services was a very limited option, thus directing efforts of the Coordinators toward collaborative efforts with existing resources, or securing outside funding for services. The purpose was to develop a potentially replicable, affordable model of comprehensive service delivery which could be used in localities with limited financial resources.

In addition to the one million dollars in direct grant support, the Hogg Foundation committed an equal amount to indirect support, primarily for evaluation of the project. The evaluation plan for the School of the Future was enhanced through consultation with directors of two earlier projects, Dr. James Comer (Comer, 1980; 1988) and Dr. Edward Zigler (Zigler, 1989), and a school-based service project in

Philadelphia funded by the Center for Education in the Inner Cities (CEIC) Project at Temple University (Keir, Culler, & Diamond, 1993). An interdisciplinary team of evaluation research consultants was drawn from the University of Texas at Austin, the University of Texas Health Science Center in Houston, the University of Texas Health Science Center in San Antonio, and Southwestern Medical School in Dallas.

The purpose of the School of the Future evaluation was (a) to assist in site planning for program development, (b) to inform key decision makers including legislators, and (c) to develop a blueprint for replication of the model. Additionally, it was recognized that the development of a large scale longitudinal database of the physical and mental health of primarily Hispanic children from low income neighborhoods was unique and could foster additional on-going research. A total of approximately 12,000 students across the four program sites were included in the longitudinal database. This report focuses on one site (Site A) with about 3,000 students.

The intervention model represented in the School of the Future was based on an implicit theory of practice that a program of comprehensive integrated family social services, made accessible through local schools, will improve family functioning, student health, mental health, and academic performance. The research question which drove the evaluation efforts was: Given a shared vision of comprehensive services and community empowerment, can a targeted investment in a single individual serve as a sufficient catalyst to identify, implement, and coordinate services to improve student mental and physical health, and academic performance?

Method

Evaluation Design

The evaluation included two primary components, a systemic analysis and an effectiveness study based on student outcomes. Although a number of students did receive direct services as a result of the School of the Future, the intervention was primarily a systemic intervention&endash;the introduction of a single individual to serve as a catalyst for the development and delivery of comprehensive services. The systemic analysis was based on a process evaluation of program implementation, including (a) an ethnographic study of the community which included repeated key informant interviews, (b) a community needs/assets assessment completed by trained neighborhood volunteers, and (c) family interviews conducted at the end of the grant period. Finally, an impact study which evaluated the relative costs of bringing services into the community and the benefit achieved for the community was conducted.

The effectiveness study initially attempted to use a quasi-experimental design including a comparison school matched for ethnicity and percent free lunch. This was later altered, dropping comparison school data and instead attempting to develop matched comparisons within the target schools. In addition, longitudinal data was collected on individual students. Nationally normed instruments were complemented by school district data on student attendance, discipline and achievement. Changes in student mental health, self-esteem, and perceptions of school climate were evaluated. The study sample included all students enrolled in the target schools. Parental consent was declined for a small proportion of students (^{2} 5%).

Measures and Data Collection

The focus of the School of the Future is the student; its ultimate goal is to improve the quality of life for children. From earlier school-based efforts, we know that changes at the school level do not occur quickly. We looked for changes at the community level which could be linked to the project as well as changes in school climate, in families who received considerable direct services, and in the physical and mental health, self-concept self esteem, and academic achievement of students.

Student surveys comprised the primary instrument for data collection using standardized instruments. All students in the target schools served as the sample. Parent consent was secured prior to student inclusion. Middle school students annually completed a survey packet during a single class period which included Achenbach's Youth Self-Report (YSR) version of the Child Behavior Checklist (Achenbach, 1991a), the "School Life" section of the National Education Longitudinal Study (National Center for Education Statistics, 1988), and Rosenberg's Self-Esteem Measure

Statistics, 1988), and Rosenberg's Self-Esteem Measure (Rosenberg, 1965). School district data was also obtained including information on grades, standardized test scores, and attendance. District data were linked to individual student's survey responses. For elementary-aged students, teachers annually completed the Teacher Report Form version of Achenbach's Child Behavior Checklist (Achenbach, 1991b). School climate was measured using an annual administration of the "Teacher School Climate" survey of the National Education Longitudinal Study (National Center for Education Statistics, 1988).

Results

Community Impact

The School of the Future project was perceived as clearly successful in all four cities. Though Hogg Foundation funding ceased in August, 1995, the project has continued and has been replicated in each of the original sites. More specifically for Site A, the School of the Future appears to have had considerable measurable direct impact on the community. Over $670,000 in new money for direct services to children and families was generated, and more than thirty new service programs in areas of health, violence prevention, parenting support, mental health, recreation, and academic enrichment were secured and coordinated. As Figure 1 and Figure 2 reflect, about 1,000 children and families per year received direct services. When multiple contacts are considered, more than 16,400 instances of service provision per year were noted (65,000 for the entire project).

Figure 3 reflects results of a benefit to cost analysis based on program component over a four year period. Some service components, such as the health care center, had higher start-up costs than others. A benefit to cost analysis was also conducted for the Project Coordinator position. Though the ratio was less than 1.00 during the first two years of the project, indicating that supporting the Coordinator was more expensive than the return in dollar value of services secured, by year five that ratio exceeded 20:1. For the five year duration of the project, the benefit to cost ratio for the Project Coordinator was approximately 4:1. A number of indirect impacts were also identified repeatedly by key informants. Among these were the evolution of a neighborhood collaboration model for the city, development of important linkages with other organizations, and the development of parents as leaders and community advocates. A conservative estimate of the indirect monetary value of the School of the Future project for the community was in excess of $1.3 million.

Student Outcomes

While it can be argued that the School of the Future project had an important direct impact on the community, the question remained whether the intervention was effective in question remained whether the intervention was effective in terms of student outcomes. Though only one site is presented in this report, and results are still considered preliminary, similar trends are apparent across the other sites. Using the norms associated with the Achenbach Youth Self-Report (YSR), students appeared much more similar to the referred sample than the non-referred during the baseline period. This raised some questions for the research team regarding interpretation. For this reason, raw scores were used rather than the norms associated with the instrument. Table 1 summarizes results of the YSR. There was no sustained significant change as measured with the YSR (p ^{2} .05).

Student self-esteem was measured using the Rosenberg Student Self Esteem Scale. Two of the ten items on this scale demonstrated statistically significant change over the three years of administration. That change was in the desired direction. Student perceptions of school climate were measured using the instrument from the National Education Longitudinal Study (NELS). Eight of the thirteen items in this scale demonstrated significant change over time (p ^{2} .05). Unfortunately, the direction of change, in each instance, was contrary to the desired direction.

Discussion

The School of the Future model is essentially a systemic intervention. There were considerable outcomes in the community which can be arguably linked to the intervention. There were no changes in student mental health, self-esteem, or school climate which could be linked to the intervention.

The use of a small targeted investment in a single individual did serve as a sufficient catalyst to identify, implement, and coordinate services; however, these services have had no measurable effect to date on student mental health, physical health, or academic performance. This may be due to such factors as insufficient strength of the intervention, inadequate timeline, inadequate sensitivity of instruments, or inappropriate sampling for evaluation. There may have been a poor match between level of intervention and design of the effectiveness evaluation, or this may have been the wrong intervention if change in student mental health is the desired outcome.

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The Florida Inclusion Network Survey Analysis and Implications

Introduction

The Regular Education Initiative (REI) was first proposed by Madeline Will, the former Assistant Secretary for the Office of Special Education and Rehabilitative Services, in the mid 1980s. The REI is a service delivery model combining special education expertise and general education expertise. REI intended to prevent student failure, instead of identifying failure. Inclusion is a component of REI. Inclusion refers to the successful participation of students having special needs within the continuum of regular education programs and the community. Inclusion means modifying traditional teaching methods, curriculum, and visions so that a broader spectrum of services and techniques is available to all students. Inclusion celebrates and accommodates diversity by pooling resources and sharing responsibilities. By bringing together general and special education teachers, learners would receive the best of both worlds and the number of children with disabilities educated in segregated programs would be greatly reduced.

Inclusion has taken on a variety of meanings and perceptions. Educators disagree about the nature of inclusion. Some proponents of inclusion promote "full inclusion" for all students and desire to eliminate the continuum of services currently available. Others advocate inclusion as part of a continuum of services designed for individual students. Feelings about inclusion vary greatly and opinions expressed about inclusion range from the excitement of teaming to deliver services to worries about job loss and increased responsibilities without proper compensation or training. For some educators, inclusion is the only way to teach. For others, it is one of the ways to serve learners. The only aspect of inclusion agreed upon by most professionals is the need for educating people about inclusion and the need for further research in this area.

Method

The Florida Inclusion Network sought to determine professional knowledge of and feelings about inclusion. A total of 180 general educators, special educators, administrators, and support personnel in the northeastern area of Florida were surveyed. These four groups were asked to respond to the following questions:

1. "What is inclusion?"
2. "How do you feel about inclusion?"
3. "How do you think inclusion will affect you?"

A total of 260 surveys were sent out, with 70% returned for analysis. Respondents were classified in terms of the position held (e.g., general educator), years of experience (e.g., 0-5 years, 6-10 years, 10-20 years, and over 20 years), and grade level placement (e.g., Pre K-6th grade, middle school, or high school). Answers for the first question were coded into one of three categories: (a) knowledgeable, (b) somewhat knowledgeable, or (c) least knowledgeable. Answers for question two were coded into one of three categories: (a) feelings expressed positively, (b) feelings expressed positively but with reservations, or (c) feelings expressed negatively. Analysis of the answers to question three were categorized by content. Consequently, survey results were analyzed qualitatively and quantitatively.

Due to the categorical nature of the data, nonparametric measures were used for analyses. Alpha was preset at .01. Researchers chose to be conservative due to the large sample size. A chi square procedure, used to detect differences in terms of knowledge about inclusion, showed that not all respondent groups are equally knowledgeable about inclusion, c2 (6, $N = 180$) = 19.63, $p < .01$. Figure 1 shows knowledge level across groups. Seasoned educators, however, did not differ from beginning teachers in terms of their knowledge about inclusion. Knowledge about inclusion also appears to be unaffected by grade level. When analyzing knowledgeable responses of general and special educators, no apparent difference between the two exists. When analyzing the least knowledgeable responses, however, the two groups do not respond similarly. When comparing knowledgeable versus least knowledgeable responses for special and general educators, a phi coefficient of .412 demonstrates a significant degree of association between group membership and level of knowledge. A particular degree of knowledge about inclusion is clearly associated with whether respondents are general or special educators.

An overall chi square analysis of feelings about inclusion shows that groups differ on this dimension, c2 (6, $N = 176$) = 20.7854, $p < .01$. Some groups feel more strongly about inclusion than others, as depicted in Figure 2. Again, years of experience and grade level placement do not have a significant impact on feelings. A chi square, based on negative feelings alone about inclusion, shows there are negative feelings alone about inclusion, shows there are differences among the groups, $c2 (3, N = 64) = 42.88$, $p < .01$. The number of negative responses is proportionally higher in at least one group. A phi coefficient of .34 demonstrates a significant association between group membership and negative responses.

Responses to the third question, how inclusion affects the respondents, varied widely. The majority of responses were focused on pragmatic issues. General educators were concerned with limited planning time and preparation for teaching students with special needs within a general classroom setting. Comments include:

- I feel I would be burdened more than I already am in planning and carrying out activities for all children of all abilities. I feel I would need to return to school to learn how to deal with many more child-related problems that are prevalent in society today.
- Inclusion makes it harder for me to assist and help all of my students when the disabled/disadvantaged student demands more of me and takes time away from other children who also need me.

Special educators reported fears of job loss and changing responsibilities. Example responses include, "If implemented, I would become either a teacher on a rolling cart or a highly educated teacher's aide," and "Inclusion will eliminate jobs." Administrators' comments focused on accessing appropriate resources to implement inclusion, providing adequate training for teachers, and "selling" the idea to parents. On the positive side, teachers responded favorably to a team approach to education, and to the opportunity to learn from each other. Example comments from general and special educators, respectively, are:

- If there are students having difficulty with a concept then one of us can take these students and work with them.
- Inclusion would allow team teaching and having an opportunity to work in the classroom with a peer would allow me to learn more and improve techniques.

Implications

Teacher education is needed if inclusion is to remain a system of delivery for special needs students. Because groups of educators differ in their knowledge about inclusion, instruction must be provided, so that a common understanding of inclusion can be established.

Groups differ in terms of their feelings about inclusion. Negative feelings, in particular, are expressed disproportionately across groups of educators. Reasons for negative feelings about inclusion, however, need to be understood for general and special educators alike. Do negative feelings arise from limited inclusion knowledge or experience with an unsupported inclusive model? The answer is unclear. Further research into inclusion is warranted.

The personal perceptions of the effects of inclusion vary. Concerns expressed by educators reveal the need for implementing appropriate models of inclusion, if inclusion is to survive into the twenty-first century. The concerns expressed by sampled educators, such as impact on planning time, job security, and changing responsibilities, must not be overlooked. Inclusion is not the only answer to problems encountered within a dual system of education. It is, however, a delivery system that must be carefully considered in the education of students with disabilities.

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Staff Development and the Inclusion of Middle School Students with EBD in Regular Education: Preliminary Findings from Project DESTINY

Introduction

Including students with Emotional or Behavioral Disorders (EBD) in general education classrooms, while desirable in many respects, has been controversial among those concerned with education and children's mental health (Fuchs & Fuchs, 1994; MacMillan, Gresham, & Forness, 1996; U.S. Department of Education, 1995). Critics have suggested that this practice may not be in the best interests of the students, their classmates, or the school community as a whole (Kauffman, 1993). A specific concern has been that, in order to effectively educate students with EBD, general educators need to broaden their knowledge in this area (Jones & Jones, 1990; Knitzer, 1982; Knitzer, Steinberg, & Fleisch, 1990).

Enhancing general educators' knowledge in the area of EBD is one of several issues being investigated in Project DESTINY (Designing Educational Support Teams through Interdisciplinary Networks for Youth with Emotional or Behavioral Disorders), a three year research project, funded by the U.S. Office of Special Education and Rehabilitative Services (Barringer & Cheney, 1995; Cheney & Barringer, in press) and designed to evaluate models for school-based service delivery to students with EBD. This summary concerns our preliminary findings regarding: (a) the knowledge and skills of teachers from two of our intervention schools; (b) the effects of two types of staff development activities (i.e., didactic presentations and case studies on teachers' perceptions of their competence in the area of EBD); and (c) the effects of increases in teachers' perceptions of their own competence on the academic and social functioning of their students.

Method

Setting

Data were collected at two New Hampshire middle schools. School A, with an enrollment of 520 students (grades 6-8), is located in a community of 9,500 residents, 98% of whom are Caucasian. School B is located in a community of 75,000, also primarily Caucasian (96%), enrolling 875 students (grades 7-9).

Participants

Participants from School A included 27 general education teachers and 3 special educators, with an average of 17 years of experience. A total of 21 had Masters degrees and 9 had Bachelor's degrees. In school B, there were 30 general and 4 special education teachers, with an average of 15 years of experience. A total of 20 had Masters degrees, and 14 had Bachelors degrees.

Using the Systematic Screening for Behavior Disorders (SSBD; Walker & Severson, 1992), teachers identified students as either typically developing or having EBD. Requests for permission to participate in the project were mailed to parents of the children whose scores were the top three on internalizing and externalizing scales from each class as well as parents of classmates considered typical by their teachers. Students having permission were then assessed using the rating scales. Finally, groups of students were designated based on the results.

Teachers, students, and parents then completed the appropriate Achenbach (1991) behavior checklist and the Social Skills Rating System (SSRS; Gresham and Elliott, 1990). Students also completed the Reynolds Adolescent Depression Scale (RADS; Reynolds, 1989). Students whose T-scores were greater than 60 on any of the Achenbach broad band scales, or above 70 on the RADS, were placed in the group with EBD. A total of 22 students with EBD (14 males, 8 females; age x = 12.9) were identified in school A, and 20 students with EBD (12 males, 8 females; age x = 13.2) were identified in school B. Twenty-seven students were identified as typical for their age and grade in school A (14 males, 13 females; age x = 12.6), and 19 were identified in School B (8 males, 11 females; age x = 13.3); all of these students scored within the average range on the screening measures.

Procedure

During the 1994-95 school year, the Project DESTINY Team (i.e., a clinical psychologist, a special educator, and a family social worker) engaged in two types of staff development: (a) the first being a series of eight didactic workshops, on such topics as developing partnerships with families, clinical syndromes, and crisis intervention techniques (Cheney & Barringer, in press); and (b) a series techniques (Cheney & Barringer, in press); and (b) a series of bi-monthly case studies of students, which included members of the school staff, and, whenever possible, the parents and students themselves.

Both schools participated in the didactic training and were scheduled to complete case studies. However, due to leadership issues and contract negotiations, only School A participated in case studies. The case studies were highly structured meetings intended to develop individualized plans for students with EBD. Information concerning 4 developmental factors (biological, interpersonal, affective, and cognitive) was collected using teacher, student, and parent versions of the same data collection forms (a sample of the student form is presented in Figure 1). Using this information, staff, students, and parents then met to identify those areas of the student's development in which support was needed. Student supports were specified in each relevant developmental area, and dates were set for review in order to assess the effectiveness of these supports. In contrast, teachers in school B met informally with the consultants, raising questions about students of concern. Students and parents did not participate in these meetings.

Measures

In both schools, the measures discussed below were administered at the beginning and end of the school year.

Teacher Knowledge and Skills Survey (TKSS). Based on two recently published lists of competencies for educators of students with EBD (Braaten, 1993; Bullock, Ellis, & Wilson, 1994), a 45 item measure of teachers' perceptions of their knowledge and skills related to EBD was constructed. A factor analysis of these items from 114 teacher surveys identified six factors, which included 36 items that accounted for 74% of the variance. The six factors were used as subscales, all of which had both acceptable internal consistency (five scales exceeded .8 and one scale alpha = .75) and item to total correlations (.4 - .7).

Students' social and emotional functioning were measured using two rating scales: the Teacher Rating Form (Achenbach, 1991), a 113 item scale, that assesses internalizing and externalizing behavior problems, and the Social Skills subscale of the Social Skills Rating System (Gresham & Elliott, 1990), which measures student progress on 30 desirable behaviors. In addition, students' grade point averages were computed for core classes in Math, Language Arts, Social Studies, and English, and attendance was recorded as days absent across a 175 day school year.

Results

Teacher Knowledge and Skills

Pre- and post-test subscale scores for teachers from schools A and B are included in Table 1. A MANOVA indicated

A and B are included in Table 1. A MANOVA indicated significant pre-test differences between the two groups of teachers (Hotellings T2 = .77, df = 6,58, $p < .01$) on all but one factor (i.e., Classroom Behavioral Assessment). In general, teachers from School A rated themselves as more knowledgeable than those from School B on the pre-test administration of the TKSS. With the exception of the Classroom Instruction subscale of the TKSS, teachers from School B had a mean rating below 3 (moderate level of competence) on a five point scale for all knowledge/skill areas. The mean score for teachers from School A was below 3 on the Theory and Characteristics, Background and Eligibility, and Classroom Behavioral Assessment subscales.

A subsequent MANCOVA with repeated measures, using teachers' pre-test scores as covariates, indicated significantly higher post-test scores (Hotellings T2 = .35, df = $p < .01$) for teachers from school A. Univariate tests showed that these differences were significant ($p < .05$) for all subscales of the TKSS except Classroom Behavioral Assessment.

Teachers' Ratings of Students

In order to discern the impact of teacher education on student performance, student measures were examined.A MANOVA with repeated measures, using TRF and SSRS data, also indicated significant pre-test differences between schools on the Social Skills subscale (F = 16.08, df = 1,76, $p < .001$), as well as a significant Student Group x School interaction

(F = 9.82, df = 1, 76, $p < .01$). In both schools, typically functioning students scored higher than students with EBD on measures of social skills, but this difference between student groups was significantly greater in School B than in School A. The results of a MANCOVA, covarying pre-test differences between schools, showed only the expected significant post-test difference between students identified as having EBD and those identified as typically functioning.

Attendance and Grades

Students' attendance and grades were also examined as indicators of the effect of teacher education on student performance. In School A, the attendance of students with EBD (M = 172.56, SD = 5.3) was comparable to the attendance of students in the typical group (M = 171.73, SD = 6.9). In contrast, students with EBD from School B attended school fewer days (M = 164.88, SD = 13.90) than students in the typical group (M = 173.70, SD = 5.6). An ANOVA of the absence data yielded a significant Group x School interaction (F= 4.57, df = 1,78, $p < .05$).

As expected, the grade point averages of students with EBD were generally lower than those of students in the typical group across schools (see Table 2). Mean grade point averages across quarterly marking periods, however, were averages across quarterly marking periods, however, were stable for both groups of students in school A, but only for the group of typically functioning students in School B. In School B, students with EBD showed both considerable variability in their mean grade point averages across the four marking periods, and a significant decline (F = 4.37, df = 1, 76) from the first to the fourth quarter. Using first quarter grades in a subsequent MANCOVA with repeated measures, however, failed to yield significant differences.

Discussion

Despite the obvious design limitations, preliminary analyses of these data have been useful in pointing out the nature of differences between the participants, and in shaping our staff development activities accordingly. With regard to the latter, our preliminary findings suggest that not all staff development methods provide the same results. When combined with traditional in-service presentations, the case study component of the model seemed to enhance outcomes for staff members. Thus, our greatest success was in school A, in which the leadership demonstrated a strong commitment to regular meetings involving teams of teachers, students, and parents. These meetings were devoted to sharing information, developing individualized action plans within a structured, developmental framework, and, in so doing, building important relationships among the participants. When compared to students in school B, students with EBD in school A had higher grades, less fluctuation in grades across marking periods, and higher attendance rates.

The case study process was also designed to increase the accuracy of teachers' attributions regarding the causes of behavioral problems. We know that teachers who attribute a student's behavior to factors beyond the student's control (e.g., family relationships, bio-medical issues, financial hardship, etc.), are generally more supportive than those who regard all rule violations as strictly volitional (Brophy, 1985). With respect to this issue, teachers from School A reported that case studies left them with both a deeper understanding of the material presented in didactic workshops and a more differentiated picture of students and their families.

Based on their deeper understanding of the students' and families' unique needs, teachers appeared better able to selectively and appropriately use the tools that had been presented in didactic seminars. Our preliminary findings suggest that the plans developed during case studies had little impact on teachers' evaluations of students' social-emotional functioning, but may have influenced both attendance and grades. During the second year of Project Destiny, we have been collecting data that bear more directly on the relationship between our measure of staff development and measures of students' functioning. In addition, we have added control schools to this year's design.

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School-based Mental Health Programs: Issues for Implementation and Evaluation

Authors

Introduction Method Implementation and Evaluation Issues
References

Introduction

The school system has been underutilized as an avenue to obtain the objectives of the Healthy Children 2000 document which contains national objectives and strategies for significantly improving the health of children (Public Health Service, 1991). In particular, the provision of mental health services within the context of the school environment enhances the accessibility and normalization of mental health services to populations of children and their families (Mash & Barkley, 1989; Meeker, DeAngelis, Berman, Freedman & Oda, 1986; Office of Disease Prevention and Health Promotion, 1993). The concept of health would be inclusive of psychosocial and emotional needs without stigmatization.

The purpose of this study was to develop, test, and evaluate a mental health intervention program implemented within the school environment. The particular program entitled "Self-Management Intervention Program for School-Age Children with Chronic Health Conditions and Their Parents" focused on the promotion of self-regulatory and stress management skills to enhance coping with a chronic health condition. The program was carried out immediately after school hours and involved 3 components: (a) twelve child group sessions; (b) three parent group sessions; and (c) 1-2 home visits.

Method

A pre- and post-test design was used to examine child, family, and system outcomes. Program outcomes were collected at various time points to represent short term and long term effects. The target group included children 7 to 14 years of age with a chronic health condition of six months or longer duration and identified by the school nurse as having difficulty coping with the stresses associated with the health condition. A total of sixty-five children participated in the program, representing 17 different schools in two school districts.

Six program implementation and evaluation issues with associated resolutions will be discussed.

Implementation and Evaluation Issues

The first issue relates to the non-categorical approach to programs that are disseminated in the community such as the school system. Typically, within the health care system, programs are organized around diagnostic groupings related to physical and mental health disorders. However, when implementing programs within the community, it is often not feasible to use categorical groupings due to the few children found in any one category. From a theoretical perspective, "generic functional skills" such as stress management and coping are relevant for many disorders; thus, it may be more important to organize programs around functional issues rather than the disorder. Stigmatization is also minimized when programs emphasize life skills. In this self-management program, children had a variety of chronic physical health conditions associated with mental health symptoms. The program's intervention focused on the self-regulatory skills of self-observation, self-monitoring, self-instruction, self-reinforcement, and self-evaluation. The intervention also addressed emotion-focused and problem-focused stress management skills. When using a non-categorical approach, several program design and evaluation challenges need to be considered. Variability within treatment groups, applicability to one's specific condition, and generalizability to the family home environment pose several challenges. Specific program components were incorporated in this study to address these challenges. For example, a family home visit was made to each family to develop individualized goals associated with the school based program goals. During each group session, attention was paid to individualized goals.

The second issue relates to accessibility and normalization. The program was implemented within a school building located within the child's neighborhood and was supplemented by 1-2 home visits. Interviews with the children and parents consistently confirmed that the convenient location of the program and lack of stigma associated with the school program setting contributed to success in recruitment and the nearly 100% attendance rate.

success in recruitment and the nearly 100% attendance rate. Children were more responsive to teachers' and counselors' encouragement to enroll in the program because its setting was school based, accessible, and did not have the stigma often associated with a "mental health center."

The third issue focuses on program integrity for both process and content. Program integrity is particularly important because multiple groups were conducted in different school sites. Assuring program integrity is a challenge when the intervention program is carried out in a school/community based environment. A curricular manual was developed with several measures of integrity obtained for group process variables (cohesion, cooperation, support, etc.), educational process components (instruction, demonstration, application to home environment, reinforcement, etc.), and program content (specific self-regulatory and stress management knowledge and skills). By measuring program integrity, the variability in the program process and content was monitored and analyzed by various statistical analyses. The relationship between program outcome results and program integrity could then be determined.

The fourth issue involves the conceptualization of program outcomes. The selection of program outcomes should capture the comprehensive nature and inter-relationship among the complexity of effects relevant to the child, family, and system. Program outcomes were categorized as: (a) child focused (behavioral-emotional problems, self system, health behaviors, and symptoms of stress); (b) family focused (relational and functional); and (c) system focused (school attendance, number of health visits to school nurse and/or primary care physician). Program outcomes were conceptualized as primary and secondary in that secondary outcomes would occur if positive change had occurred in the primary outcomes. For example, a positive change on a child's self-regulatory knowledge and skills coupled with fewer symptoms of stress could be associated with the secondary effects of fewer visits to the school nurse. Both short-term and long-term effects were examined for patterns across time and for the sequencing of primary versus secondary outcomes.

The fifth issue relates to the generalization and transfer of program effects to daily living at home and in school. Two inter-related questions were asked. Did children demonstrate new knowledge and skills within the program sessions? If so, to what extent did the children apply their newly obtained knowledge and skills to daily living at home and school? In other words, was the child able to transfer learning from the program sessions to other settings? These evaluation questions were answered by obtaining data from parents, teachers, and school nurses. The schools who participated in the study varied in the type of community based environments offered to children including mental health education and clinical services. Thus, the availability of school resources designated to support the study's intervention program influenced the extent that the intervention generalized to the school environment. Parents indicated that periodic booster sessions after completion of the intervention would have been helpful in order to support and sustain the newly learned behavioral patterns over time.

The last issue relates to individual differences, differential program effects, and program matching. Designing programs both for populations and for subgroups within populations may be a way to resolve the delicate balance issue of recognizing individual variations within populations and thus matching variations within program to variations within populations. The variations in the schools' emphasis on mental health resources and services reflected to some extent the community's attitudinal and financial support of these services. The design and efficacy of school based intervention programs need to take into consideration the broader context of the community.

As indicated in the federal document, School Health: Findings from Evaluated Programs (1993), school health programs and evaluations varied considerable across the nation. While ideally school health programs need to address the full range of health promotion services, including mental health, the majority of school health programs are not comprehensive. Program design and evaluation need to be considered carefully in order to generate a data base that offers insight into how school programs may assist families and communities in meeting the many needs of school-aged children.

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The Elementary Mental Health Operations Evaluation

Introduction

A 1986 Needs Assessment report conducted for the Juvenile Welfare Board (JWB), an independent special taxing district that funds delivery of children's services through other agencies, identified Pinellas County Florida as an area where children with emotional handicaps (EH) were undermet. In response, JWB began funding four Elementary Mental Health Operations (ELMHO) programs in Pinellas County. The purpose of the ELMHO programs was to provide school-based mental health services to the children and their families to help elementary students with emotional disabilities learn to cope with their issues well enough to mainstream back into less restrictive academic settings. The program's intentions were to demonstrate the effectiveness of intensive mental health intervention with this EH population with "mild to moderate" disabilities through improvements in behavior, increased mainstreaming, and decreased placement in more restrictive settings.

Method

Subjects/Sites

There were four program sites; three of the sites involved students with emotional disabilities while the fourth site was moved within months of inception to a center for students with severe emotional disturbances (SED) as a result of the school system relocating the students.

Intervention/Program

The programs would address: (a) the child's behavioral problems and level of functioning through individual, group, and family counseling; (b) identified family problems through parent training and family counseling; and (c) consultation with teachers to help them develop problem solving strategies to work with these children.

The ELMHO program process was simple and straightforward. After a teacher referred the child, the therapist assessed the eligibility of that child. If parental permission was received, individual, group, and family counseling, case management, and psychiatric/psychological examinations were provided. The child could exit the program for reasons such as mainstreaming, "graduating" to middle school, leaving the school, or lack of progress. The program provided services in a natural setting, thought to be less threatening to families than agency-based mental health services.

Measurement

The evaluation of this program consisted of: (a) interviews including those with parents, school principals, social workers, program supervisors, agency directors, and JWB staff (N = 62); (b) school record reviews of all EH students at 3 target schools, a sample of SED students at the SED center, and all EH students at two non-ELMHO schools (N = 396); (c) case record reviews (N = 100); and (d) case studies (N = 11).

Results

Length of Stay

Participants stayed in the program longer than was originally intended. Evaluation data suggest that children with the most severe rather than mild to moderate disabilities were referred to the program. These children needed long term care beyond the prevention and early intervention components the ELMHO program was intended to provide. This excessive length of stay also reflected an apparent dependency on the program. Many ELMHO children reported not being ready to leave EH classrooms, and some reported that they intentionally misbehaved to stay. Parents expressed concern over what misbehaved to stay. Parents expressed concern over what they would do when their children were promoted to middle school.

Parental Participation

The evaluation showed that involvement of the whole family in the interventions was critical to significant progress. If parents did not "buy into the program," then the child could be confused by the expressed wishes of the parents/family and the wishes of the program, limiting or preventing bonding among participants. It appeared that many of the families being served by the programs had a multitude of issues, making work with families difficult outside of the structured classroom setting.

Findings showed that more families/siblings needed to be involved in these programs. Service level numbers and comments by families indicated that children were often being served in isolation. Given the issues surrounding these families, nontraditional parent involvement strategies may need to be employed. It appears that the programs should also support development of community support services outside of mental health agencies so that families are able to independently seek additional help in the community.

Service Need

Accessing families through the school is a non-threatening way to reach individuals who might otherwise not seek help. There appeared to be a need for an increase in both the amount and types of mental health services available in this setting for children identified with an EH educational status. The level of services provided by the schools did not always meet the identified need of the child, because resources remain scarce within the school system.

School System Issues

According to the school system, there was no clear system in place to track students through the mainstreaming process. This made the development of some goals and objectives for ancillary programs, such as ELMHO, more difficult. As it currently operates, the goal of mainstreaming may not be a measurable, realistic objective for this program. Methods to recruit and serve children with less severe disabilities need to be developed, the desired outcomes need to be redefined, and/or a new approach to serving the intended target families needs to be considered.

Another issue is the need for trained teachers. According to the school district informants, there is a critical shortage of exceptional education teachers. Children can be negatively impacted by limited teacher training.

A final issue is that of appropriately ending services to children and families. The ELMHO program served the majority of the children with emotional handicaps in these four schools, making it difficult to close cases on children four schools, making it difficult to close cases on children who have not left the classroom and/or school. The children may not understand why they no longer receive "special attention."

Service System Issues

Concern arises in regard to labeling young children with both mental health diagnoses and exceptional identification by the schools. Labeling can lead to self-fulfilling prophecies for failure in the client. By focusing on children with less severe levels of disability, labeling may be prevented.

Mental health agencies have begun to bill Medicaid, insurance, and/or families for the ELMHO services. Several concerns regarding this practice include: (a) the program was originally free to families and is still seen as such; (b) there is a need for a diagnosis/label to obtain reimbursement; and (c) the potential exists to have clients selected on the basis of income source, or to have treatment plans designed around what Medicaid/insurance will pay rather than on the needs of the client.

Carryover of clients from one year to the next was also found to be excessive and distorted true service levels due to a lag in record keeping. Cases closed during this program year at one site averaged 31 months from the last contact and the case being closed. Cases at other sites ranged from 5 months to 12 months between last contact and cases closing. Some of this lag was due to delaying paperwork until the slower summer months of the program.

The SED Center

The SED Center did not appear to be an appropriate site for the ELMHO program, for a number of reasons:

- Documentation (i.e., medical history, lost records, etc.) required by the program was consistently deficient.
- These children had more severe impairments than the population that the program model was designed to serve. The center had a very structured environment; the center's point and level systems did not provide teachers the flexibility to adequately accommodate individualized treatment goals. Children were required to complete two transitions before going back to their regular school, making this process long and difficult for these children.
- Most of the children in the SED program were Medicaid eligible. As before mentioned, there are concerns surrounding utilization of Medicaid-driven rather than client-driven admission and service levels.

Discussion

The original intent of the ELMHO program was to provide prevention and early intervention for children newly diagnosed as having emotional disabilities to help stabilize and mainstream them back into regular education classes. It slowly evolved into a program which appeared to serve children with the most severe problems, providing stabilization for them until they "graduate" to middle school. After leaving the program, the gains made while in the program appeared to be lost, and the children's problems continued to increase in severity. The "drift" between program intent and function clearly needs to be addressed. A beginning point might include the development of a problem solving team, including both representatives from JWB and the mental health agencies, with input from the school system.

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Chapter 10

Assessment of Service & Training Needs

Education and Training of Children's Mental Health Professionals: The Existing and Potential Role of Schools of Public Health

Introduction

In the early 1980s, a landmark national study by Knitzer (1982), conducted on behalf of the Children's Defense Fund, found a widespread failure of states to meet the service delivery needs of children and adolescents with serious emotional disorders. In that study, only 21 states were found to have a child and adolescent mental health unit, and it was estimated that approximately two-thirds of children with serious emotional illnesses were not receiving needed services.

Since the publication of this study, increasing attention has been given in the literature to the conceptualization, development, and implementation of integrated and comprehensive mental health systems of care for children and adolescents (Burns and Friedman, 1990; Friedman and Kutash, 1992; Jordan and Hernandez, 1990; and Stroul and Friedman, 1986). Davis, Yelton, Katz-Leavy, and Lourie (1995) recently reported significant progress in the organization and support of children and adolescent mental health services due, in part, to initiatives by private foundations, the passage of federal legislation, increased interagency collaboration, state legal mandates and court orders, and expansion in the availability of alternative mental health services.

Meanwhile, within the educational systems throughout the United States, research has suggested that educational services for children with emotional and behavioral disabilities have been inadequate and have resulted in poor outcomes for children (Knitzer, 1982; Knitzer, Steinberg, & Fleisch, 1990; Knitzer, 1993; and Wagner, D'Amico, Marder, Newman, & Blackorby, 1991). According to the Office of Special Education and Rehabilitative Services (U.S. Department of Education, 1992), these children have lower graduation rates, lower grade point averages, and are less likely to continue in school compared to all students.

Prompted by these findings and in response to the need for improving the outcomes for children/adolescents and their families, a shift in both the conceptualization and practice within an integrated mental health system of care is in progress. The recent national study reported by Davis et al. (1995) found significant progress nationally (since 1982) in the organization, financing, and delivery of mental health services to children and adolescents. Nevertheless, in considering this new children's mental health paradigm of community-based systems of care, Knitzer (1993) and Davis et al. (1995) have maintained that there are presently few well-trained professionals and leaders focusing on collaborative initiatives in children's mental health service delivery. Additionally, Duchnowski and Friedman (1990) have discussed the need for developing improved undergraduate and graduate curriculum to train professionals who will staff, organize, and manage these emerging systems of care. Furthermore, Duchnowski and Kutash (1995) have suggested that training individuals in children's mental health services should ideally be provided within an a multidisciplinary, public health perspective.

It is, of course, not enough to proclaim a new paradigm shift within the mental health system without infusing this re-conceptionalization, organization, and delivery of child and adolescent mental health services into a comprehensive education and training agenda. This paper provides readers with a summary of the existing capacity for and potential to expand education and training opportunities in children's mental health services through a public health perspective.

Method

A national survey was utilized to summarize the existing capacity for and potential to expand education and training opportunities in children's mental health services within schools of public health. A two page, nine item, self-administered questionnaire was developed and sent to all 27 schools of public health in the United States and Puerto Rico which were accredited (as of the fall, 1995) by the Council on Education in Public Health. The survey instrument sought information on the existence, substantive nature, and availability of mental health and substance abuse courses, areas of concentration, as well as degree programs within these colleges of public health. It also contained questions which sought information on how these courses and programs were organized within the schools of public health. Additionally, the survey contained questions which permitted the collection of information regarding child and family health courses which were offered during the 1995-1996 academic year.

Results

Mental Health

All 27 questionnaires were completed and returned, resulting in a 100 percent response rate. Nineteen of the 27 schools of public health offered courses in mental health services, with 12 of these 19 schools offering two or more mental health courses for the 1995-1996 academic year. Eighteen of the 27 schools of public health offered courses in social and behavioral sciences.

A variety of mental health courses was taught in the 19 schools of public health. However, the topics most frequently offered were mental health epidemiology (25 courses taught nationally), mental health planning, administration, policy and law (12 courses taught nationally), mental health statistics and research (11 courses taught nationally), children and family mental health services (eight courses taught nationally), and stress (seven courses taught nationally). The courses taught in children and family mental health within schools of public health included: Family and Mental Health (University of California at Los Angeles); Childhood Mental Disorders: Public Health Perspectives (Harvard University); Children's Mental Health (University of Illinois at Chicago); Epidemiology of Children's Psychiatric Disorders (University of Pittsburgh); Mental Health of Children and Adolescents (The University of Texas); An Introduction to Personality and Cognitive Development: Application to Maternal and Child Health (Harvard University); Child Development and Psychopathology (Johns Hopkins University); and Public Health Interventions for Prevalence of Youth Violence and Depression (University of South Florida).

The mental health courses were organized in a variety of departments within the schools of public health. Only Johns Hopkins University organized all of the mental health courses into an independent departmental structure (Department of Mental Hygiene). Nevertheless, 15 schools of public health contained health education, health behavior, and/or social and behavioral sciences departments, while eight schools housed maternal and child health departments.

A total of nine schools of public health offered either master's degree programs, doctoral degree programs, post doctoral degree programs, or areas of concentration in mental health services (Loma Linda University, University of California at Berkeley, Yale University, University of South Florida, University of Illinois at Chicago, Harvard University, Johns Hopkins University, Columbia University, and University of Pittsburgh). Furthermore, two schools of public health (Johns Hopkins University and University of Minnesota) offered certification programs in mental health. For the 1995-1996 academic year, there was a total of 37 post doctoral fellows in mental health attending seven schools of public health (University of California at Berkeley, Yale University, University of Illinois at Chicago, Harvard University, Johns Hopkins University, Columbia University, and University of Pittsburgh).

Substance Abuse

Substance abuse courses were offered by 14 of the schools of public health. Ten of the 14 schools of public health offered two or more substance abuse courses during the 1995-1996 academic year. Johns Hopkins University and the University of Minnesota offered five substance abuse courses, while both the University of California at Berkeley and Loma Linda University offered four substance abuse courses.

A total of six schools of public health offered areas of concentration, post doctoral programs, and/or certification programs in substance abuse (Loma Linda University, Boston University, Harvard University, Johns Hopkins University, University of Pittsburgh, and University of South Carolina). For the 1995-1996 academic year, there was a total of seven post doctoral fellows in substance abuse attending two schools of public health (Johns Hopkins University and the University of Pittsburgh).

Discussion

Although the first generation of schools of public health was established prior to 1920, almost one half of the total schools of public health were established and accredited after 1960. These interdisciplinary institutions have significantly shorter histories of producing graduate students, vis-a-vis graduate programs in the core disciplines of mental health services (e.g., psychiatry; psychology; social work; and psychiatric nursing). As interagency and collaborative comprehensive systems of care for children collaborative comprehensive systems of care for children and their families emerge within communities, higher education faces a tremendous series of both challenges and opportunities to participate in the education and training of children's mental health professionals from a multidisciplinary, public health perspective.

Public health, by definition, examines health and disease from multidisciplinary and community perspectives. Prevention and early intervention orientations are basic foundations in public health. When examining systems delivery, a public health framework incorporates an epidemiologic perspective, drawing on theories from medicine, biometry, environmental and occupational health, economics, sociology, business, and many other disciplines. Thus, a public health perspective examines the entire array of problems faced by a specific population. Additionally, many schools of public health have developed cross training and multidisciplinary (joint) degree programs with other graduate/professional programs, including social work (M.P.H./M.S.W. programs), medicine (M.D./M.P.H. programs), and law (J.D./M.P.H. programs). Thus, there inherently exists within schools of public health unique opportunities to utilize their existing capacity to train mental health professionals working with children and their families.

The results of this study indicated that the majority of the schools of public health (70 percent) do not currently have a comprehensive curriculum and/or the expertise available to train practitioners to work with children and youth with emotional disorders. Historically, this lack of multidisciplinary and cross-training of professionals can be attributed to the fragmentation of the children's mental health delivery systems that currently exists (Duchnowski and Kutash, 1995).

Nevertheless, clearly, schools of public health do have the capacity to develop and create expertise in both the mental health services delivery and the child and family health fields. Currently, nearly three quarters (74 %) of the surveyed schools of public health indicated that they offered degree programs, courses, post-doctoral fellowships, and/or continuing education opportunities to assist mental health professionals in becoming more oriented toward prevention and early intervention paradigms. Additionally, 44 percent of the schools of public health indicated offering both mental health and substance abuse courses.

The authors are currently working with the University of South Florida College of Public Health in developing an area of concentration in mental health and substance abuse services at both the master's and doctorate levels. This area of concentration in mental health and substance abuse would be open to students from any of the four departments within the USF College of Public Health. Furthermore, graduate students enrolled in the Doctoral Studies in Child and Family Policy (based in the USF Department of Special Education and the USF/FMHI Department of Child and Family Studies) would also enroll in these mental health courses, in order to train future professionals in collaborative integrated systems of care for children and adolescents.

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Multicultural Mental Health Training Program: Researcher Projects With Ethnically Diverse Communities

Introduction

Richard Briscoe, Ph.D.

These summaries present the research projects of three graduate students participating in the Multicultural Mental Health Training Program (MMHTP) at the University of South Florida's, Florida Mental Health Institute (FMHI). These students' work involved the development of evaluation or research projects with ethnically diverse minority communities.

The purpose of the MMHTP is to increase the number of ethnic minority mental health professionals in the state. The training program provides students, university and agency staff with practical techniques applicable to mental health service delivery in minority communities (Briscoe, Sedberry, & Henderson, 1996). The National Institute of Mental Health (1991) advised that additional research was needed to support service delivery to minority populations. MMHTP collaborates with the Multicultural Child and Family Project (MCFDP) at the FMHI in developing evaluation, technical assistance and training strategies aimed at improving the effectiveness of innovative community-based neighborhood programs which serve ethnically diverse populations (Briscoe, Wright, & Yang, 1994). Effective interventions with ethnically diverse communities address the cultural values and unique needs of local communities, because ethnic or racial groups differ in their relevant cultural values, norms, expectations, and attitudes (Isaacs & Benjamin, 1991). The MCFDP and MMHTP embrace a neighborhood-based approach to delivery of social services, and conceptualize three theoretical orientations which enhance the system of care model's applicability to ethnically diverse populations: (1) neighborhood-driven participation which emphasizes natural support networks within the community and democratic participation; (2) primary prevention to promote the well-being of families and communities; and (3) cultural competence on the part of change agents to incorporate the concerns and values of the local residents into effective programming.

An aim of the following research projects was to develop collaborative ties between ethnically diverse communities and the university to increase the effectiveness of service delivery. The first summary examines the strengthening of linkages between the community and schools. National educational goals recognize the importance of partnerships between schools and the home to the educational achievement of children. How these linkages are perceived, created and maintained in a predominantly African-American community was the focus of this dissertation in Applied Anthropology. The second summary reports the development of a community-based job services program. This project involved the coordination of multiagency family career and job placement services to transition low income community residents into improved employment and self sufficiency. The third summary, from a public health perspective, addressed communicating health information effectively to members of middle income African-American communities. This project involved promoting proper management of household hazardous waste to improve indoor air quality and decrease the prevalence of childhood respiratory ailments.

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Working Together for the Children: School-Community Partnerships in East Tampa

M. Yvette Baber, M.A.

Introduction

This report details the results of a qualitative evaluation of a locally-based effort to increase levels of interaction between schools and parents from East Tampa, FL.

Multicultural Community and Family Development Project. The Multicultural Community & Family Development Project (MCFDP) at FMHI has worked with the East Tampa School-Community Partnership (ETSCP) for the past five years to stimulate the development of a coordinated system of parent-school partnerships among the elementary and secondary schools serving the area. This internship assignment was to provide evaluation and professional support services to the East Tampa School-Community Partnership and to assess the ways in which ETSCP has achieved its stated purpose.

East Tampa School-Community Partnership. In the late 1980s, one problem that was evident to the Lee Davis Neighborhood Service Center (LDNSC) and a parent from an elementary school was the disproportionate level of suspensions and expulsions for children who lived in East Tampa. The East Tampa School Children Advocate Committee was formed in 1990 to provide a network of school and community support to address parents' lack of access to their child's school, misconceptions about the community or the School District, and the high levels of disciplinary actions experienced by the children from East Tampa. In 1992, the name of the organization was changed to the East Tampa School-Community Partnership (ETSCP). Each month since then, principals, teachers, parents, school district staff, and social service staff have met to discuss these issues.

The stated purposes of the ETSCP are: 1) to develop a network of concerned citizens to bridge the communication gap between home and school by identifying obstacles to healthy communication in the arena of education, and 2) to develop strategies to increase home-school communication in the arena of education. As the organization nears its fifth full year of operation, it is beginning to examine how it has reached its goals, with a focus on strengthening the Partnership's infrastructure and increasing local parent involvement in its activities.

Evaluation Methodology

Evaluation Methodology

The assessment of ETSCP was conducted using a multi-method approach. First, a review of the literature related to participation and school involvement in African-American communities was completed. Historical documents were reviewed, and a draft evaluation of the ETSCP (MCFDP, 1995) provided critical statistical information on organizational changes. This effort identified key topics which were discussed, initiatives which were undertaken, and those individuals who had consistently attended the meetings of the organization. An intensive review of the partnership's efforts (January - December 1995) identified its accomplishments for this period. This review produced a picture of an organization staffed completely by volunteers that has consistently worked to bring parents and teachers together for the education of East Tampa's children.

The anthropological focus of the evaluations made participant observation a primary research tool. Intense involvement in general membership meetings and board meetings contributed to an understanding of the dynamics of interaction and communication between members of the partnership, the Hillsborough county school system, and the East Tampa community. In addition to these meetings, the author attended the open parent-school events scheduled at the Lee Davis Neighborhood Service Center or involving the ETSCP (Back-to School Kickoff, Parent Enhancement Conference, Christmas Giving Tree). Individuals who belonged to the ETSCP were interviewed about their experiences and perceptions. These individuals were selected based on their membership in the organization and their willingness to be interviewed. They consisted of community residents, school district staff, principals and assistant principals of partner schools, and social services staff from the Service Center.

Evaluation Findings

The review of records indicated that the ETSCP has, in fact, drawn a diverse group of educators, social service staff, residents and parents together. School and agency information was shared at virtually every meeting, and community concerns were addressed consistently over the past six years. From these efforts, vehicles to link schools and community were created. The Back-to-School Kickoff is an annual event where schools come to the community to meet and provide information to parents, and where children are given school supplies. It has grown from serving 200 people in its first year to almost 1,000 people in 1996. Additionally, the Full Service Schools Program in East Tampa was developed and funded as a result of the efforts of ETSCP members and is now an integral source of school-based services.

There are programs and schools that have also maintained a consistent relationship with ETSCP. The public library, the Tampa Police Department, the LDNSC, the Head Start

Tampa Police Department, the LDNSC, the Head Start Program, and the Tampa Housing Authority have sent representatives to meetings for the past four or five years. There are some schools that have demonstrated a commitment to linkages and working together for the children through their regular participation and involvement. Nine Hillsborough County Schools have sent representatives to meetings on a regular basis since 1991. These schools, and their staff, have been key players in ETSCP's efforts to increase home-school communication.

The number of parents who attend the monthly meetings has also increased over the years, and 1995 showed the most impressive participation. At the beginning of the year, the number of parents varied from 2-5. From July to the end of the year, the numbers increased, and were in the range of 5 - 16 at each meeting. The Partnership is, indeed, bringing schools and parents together to bridge the gaps of communication and cooperation that had, in the past, plagued the East Tampa community.

The individual interviews revealed that the people who have joined the partnership are convinced that it is a valuable organization and that they are better able to serve the children of East Tampa because of its work. School district personnel expressed concern over low levels of parent involvement in the schools, but they were able to experience parent involvement at the community level through Partnership activities. Parents, teachers, and principals all felt that working together on planning committees and at ETSCP events helped them understand each other better. Parents expressed more confidence in approaching school site staff (teachers, counselors, etc.) and reported that they appreciated the opportunities they were given to meet with these people in their own community.

One factor that came up consistently in meeting discussions, interviews, and casual conversations was the impact of district-wide bussing on the relationships between schools and parents. Parents said that they could not easily get to some of the schools that their children attended because of a lack of transportation. Social services and school staff talked about the inability to make a personal connection with parents and the way it affected classroom management, resolution of problems, and support for the school programs. All groups acknowledged the importance of parent-school-community linkages but expressed frustration at finding a way to build those linkages. They saw community-based events as one effective tool to draw parents out and emphasized the need to continue to reach out to the "grass roots" in order to build their trust and participation.

Conclusion

The success of ETSCP continues on its upward spiral - drawing more people to its general meeting and working hard to reinforce the developing linkages between schools hard to reinforce the developing linkages between schools and the community. The qualitative evaluation of the process of achieving this goal has shown that long-term volunteer efforts can succeed with consistent participation and a continuing focus on the purposes of the organization. The Partnership helps close the gap between schools and residents of an inner-city neighborhood&endash;a gap created by forces beyond the control of either the parent or the schools. Parents and school personnel can meet and work together on projects for the children that are community-based. The school personnel gain an understanding of the environmental realities of their students, and the parents gain confidence in their ability to communicate effectively with the people responsible for the schooling of their children. The Partnership has gained district-wide attention for its efforts, and discussion is now underway about how to develop similar partnerships in other neighborhoods in Hillsborough County, Florida.

Community-based Job Services Programs: The First Step Toward Community Economic Revitalization

Tracy Lea McPhail, M.A.

Introduction

This summary describes the use of community-based job development efforts to initiate economic revitalization.

The issue of welfare reform and the need to economically revitalize certain communities in Tampa prompted the community leaders and concerned faculty at the University of South Florida (USF) to address ways to transition low income welfare recipients toward gainful employment and self-sufficiency. The Center to Develop Communities of Tampa (CDC of Tampa), formerly known as the Lee Davis Neighborhood Development Corporation (LDNDC), has been dedicated to developing and sustaining community enhancement programs for many years. Such programs include the Men to Boys program which pairs successful African-American men with African-American boys who are at risk for developing problems in the community. Another successful program is the East Tampa School-Community Partnership which has been instrumental in opening the lines of communication between school administrators and concerned citizens.

A 1993 Needs Assessment of East Tampa Residents revealed that the respondent's top three needs were jobs, day care, and affordable single family housing. The urgency of these needs prompted several partnerships between the university and community organizations. One such partnership was initiated by Florida Community Opportunity Partnership Center (FCOPC) and Multicultural Child and Family Development Project of the Department of Child and Family Studies at the University of South Florida's, Florida Mental Health Institute. These projects at

Florida's, Florida Mental Health Institute. These projects at the USF united with the LDNDC, the Department of Labor and Employment Security (DLES), and the City of Tampa Private Industry Council (PIC) to create "one stop" community-based job development centers. These facilities would serve as a tangible first step in transitioning the unemployed toward self-sufficiency. One-stop job development centers are designed to provide referrals for jobs, vocational training and education. These centers are comprehensive, in that they also address many barriers to sustaining employment such as day care/elder care and transportation.

East Tampa is one of four sites for job development centers. The Job and Education Placement Center (JEPC) is housed within the Lee Davis Neighborhood Development Corporation (LDNDC). The JEPC is designed to address the needs of the unemployed and underemployed residents in the target area. With the help of the aforementioned entities, the JEPC provides many services to their clients. The DLES has set up several job information services terminals which clients use to electronically search for jobs posted by employers in four Florida counties. For clients who are unsure of their career path, the JEPC provides a computerized vocational assessment tool that prompts the clients to answer questions concerning their skills and interests.

In addition to referring clients to area vocational schools, JEPC also offers two job training programs. Job readiness training provides forty hours of customized instruction and hands-on practice designed according to the employer's human resource needs. The Florida Aquarium used JEPC's job readiness training during its initial staffing. The JEPC also offers an employability skills training program. This program consists of weekly courses on issues such as resume writing, interviewing skills, and proper business attire. This training is offered in several locations in East Tampa including the Lee Davis Neighborhood Service Center and various housing developments. When training participants appear to have low self-esteem, the staff conducts motivational exercises before presenting the traditional employability training material. These exercises help the program participants recognize their worth, while identifying the skills they can offer to prospective employers.

After all job searches and job readiness evaluations are completed, the client may be referred to a job or a vocational training facility. If job or education placement occurs, then the JEPC should monitor their clients' progress for 90 days. The current staff capacity at JEPC does not allow for comprehensive monitoring of all clients.

Program Evaluation

Within its first month of operation, JEPC had served 90 clients. All the client demographic data was not available, clients. All the client demographic data was not available, however simply comparing the responses of the needs assessment to JEPC's client's in its first month of operation shows that JEPC is truly serving a much needed function in the community.

Five months later, more than 350 people have visited the CDC of Tampa office. Of those people, 74 have been placed in jobs, demonstrating a one out of five placement rate. This placement rate is two placements higher than the larger Job and Benefits Offices. The types of jobs vary from janitorial work to mechanical engineering. The types of organizations that have hired clients include GTE Mobilnet, Ametek, USF, and Creative World Day Care.

Jobs and Community Revitalization

When examining the community economics from a macroeconomic perspective, it is clear that jobs are the first steps toward community economic development. Communities like East Tampa are constantly recruiting businesses to locate in their area. Businesses are attracted to a locale's amenity factors such as tax incentives, skilled workers, quality education, quality transportation, and a low crime rate (Kasarda & Irwin, 1991). East Tampa is fertile ground for economic revitalization. As a federally designated enterprise zone, businesses located within the target area receive tax incentives and other perks.

Community-based job centers are a crucial link in improving the amenity factors that can attract businesses to the area. As businesses use the JEPC to find qualified, responsible employees, the residents acquire income that can be spent within the community. Continued efforts to recruit more businesses in the community will help diversify the local industry mix. The revenue from goods and services consumed (and eventually produced) in East Tampa will contribute to the community's economic expansion. The process all begins with jobs (Hindley, 1981; Kasarda & Irwin, 1991).

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Health Information Effectively to Middle-Income African-American Communities

Kimberly Michelle Harper, M.P.H.

Introduction

One of the primary goals of this study was to determine the preferred sources of health information for middle-income African-American families, as well as how health risks are perceived differently among ethnic populations. The health risk example identified for this study was exposure to environmental contaminants, as the condition and quality of one's surrounding environment can have significant influence on physical, mental, and emotional health. The most common exposure to environmental contaminants occurs in our homes with common household products that contain hazardous chemicals. This summary describes this exploratory research's methodological procedures and preliminary implications.

Methods

This study's selected target population, middle-income African Americans, is one of the fastest growing economic sectors in American society. Currently, three out of ten African-American families in the United States have attained middle-income socioeconomic status. Conveying health information effectively to these families should be a primary concern for prevention. To be eligible for this study, participants had to reside in Hillsborough County, live in a single-family dwelling, and have at least one child under the age of ten years old.

This study used direct observations, elite interviews, focus groups, and community surveys to gain information on perceptions and preferred sources of health information, as well as more specific concerns and behaviors related to environmental health Fifteen direct observations estimated product preferences, usage levels, and storage methods. Thirty interviews with community leaders provided insight about the target population; quotes from focus groups also were instrumental in designing preliminary health messages using the cultural cues and values from middle-income African-American parents. Results of these qualitative research methods reflected a range of opinions and concerns, and proved beneficial to preliminary development of community surveys. These surveys were distributed to a sample of 250 homes from six selected neighborhoods in Hillsborough County. The selected neighborhoods were comprised of at least 50% African-American residents, based on 1990 Census data. At least 40% of the households had children present, and at least 40% of the households earn more than $25,000 per year.

So how does this study translate into practical application? Preliminary analysis suggests:

1. With a limited number of ethnic populations utilizing available mental health services, it is imperative to address current health concerns in the marketing of current resources through a focus on the community strengths.
2. Cultural cues and pivotal messages may be slightly

more distinct for such a specific demographic population. Thus, quotes from interviews and surveys may serve to peak the interest when describing available programs.

3. Due to this population's typically strong and constant spiritual beliefs, an avenue of joining forces with a particular religion's or denomination's health ministries may be explored further.

Environmental Psychology Implications

On another level, perceptions of the environment or surroundings may yield a reflection of mental health influences. Nature or environmental experiences can help broaden our sense of the world while deepening our sense of ourselves (Wals, 1994). Qualitative and quantitative findings suggest that those residing in urban ethnic communities, without regard to socioeconomic status, are often exposed to excessive air, water, and soil pollution. A common response is concern for the cumulative impact on their children's health twenty years from now. Door-to-door community surveys revealed shared concerns and emotions that require solution to ensure the stability of future physical and mental health.

Feedback

The community survey data, complemented with qualitative approaches, will provide concrete suggestions and strategies for addressing a distinct ethnic population with multiple community networks throughout the socioeconomic scale within the black community. Feedback to the community is a critical component of any research. In this instance, the community will receive information in the form of data that can be transformed to program ideas, radio talk shows, newspaper articles, and meeting presentations. Based on the information and concerns expressed, an environmental education program can be designed to include topics of most interest to the communities, increasing adults awareness of the impact of environmental contaminants on the family's physical, mental, and psychological health.

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Conclusion

This symposium was intended to highlight the research projects of students participating in the MMHTP in coordination with the MCFDP. These research projects address the overall objective of the MMHTP to improve the quality of services to minority communities through a combination of training, research and treatment services. These minority student researchers are dedicated to understanding and studying the mental health needs of an increasingly ethnically diverse population. Initially, the MMHTP placed students in community sites to offer treatment services and technical assistance. These current students are combining research and evaluation procedures to improve service delivery within communities. Data collected in these projects involved community-based programs or community residents. The data gathered required formal and informal linkages between community residents and the researchers. The roles of these researcher are viewed as collaborators or partners for successful service delivery. The MMHTP will continue to offer minority students the opportunity to develop research projects and collaborative approaches for improving service delivery with ethnically diverse populations.

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The Continuum of Care Study: An Assessment of Child/Adolescent Service Needs Within the Public Mental Health System

Introduction

Given the current fiscal environments in which State Mental Health Administrations are operating, there is increasing pressure to develop empirical methods of assessing need and allocating resources. In 1995, the Virginia Department of Mental Health, Mental Retardation, and Substance Abuse Services (DMHMRSAS) conducted a study to evaluate the need for services across the continuum of child/adolescent mental health services. The specific objectives of this study were to: (a) describe the youth receiving services, (b) determine where and to what extent gaps in services exist, (c) determine the reasons why youth do not receive services, (d) empirically classify youth on the basis of "service packages" received (or identified as needed), and (e) identify those sociodemographic, clinical, and treatment history variables that best predict the service packages identified as needed.

Method

Data were gathered through a survey of community-based case managers (or primary clinicians) on a stratified random sample of youth who were receiving public mental health services on December 31, 1994 (N = 2,059). This population was divided into two distinct sub-populations, youth with serious emotional disturbance (SED; N = 1,100) and non-SED (N = 959) to determine whether their service needs differed.

Respondents to the survey provided (a) descriptive data about the youth, (b) the types and amounts of services received during the last quarter of 1994, (c) the types and amounts of services that would have been needed to most appropriately and effectively serve the youth during the quarter as estimated by the youth's case manager or clinician, and (d) reasons for differences between services received and needed (e.g., service not available, insufficient service capacity, etc.). Gaps in services were determined by calculating the difference between the types and amounts of services provided and the types and amounts of services needed.

Using cluster analysis, "typical" service packages were identified, based on services recommended as needed by the case managers/clinicians. The youth were then classified according to cluster membership and a discriminant function analysis was conducted using sociodemographic, clinical, and treatment history variables to determine which variables best predicted recommended service packages.

Demographic variables that were included in the discriminant function analysis included age, race, gender, educational level, special education enrollment, residence in private household, legal status (voluntary vs. involuntary), annual income, SSDI eligibility, SSI eligibility, and payment source. Clinical variables used in the analysis included number of prior episodes, history of previous psychiatric hospital admissions, SED status, and score on the Global Assessment of Functioning (GAF). Due to the low frequency of some of the diagnostic categories used in the survey, primary and secondary diagnoses were grouped into the following categories: (a) schizophrenia and other psychoses, (b) adjustment disorders, (c) mental retardation or pervasive developmental disorder, (d) attention-deficit or disruptive behavior disorders, (e) anxiety or mood disorder, (f) substance dependence or abuse, and (g) other.

Results

Consumer Profile

The typical youth enrolled for services at a Community Mental Health Center (CMHC) in Virginia was a male (60%), 13 to 17 years of age (50%). African-American youth were over-represented relative to their percentage in youth were over-represented relative to their percentage in the general population (29%). Half of the youth with SED were enrolled in special education. The majority of these youth (83%) came from families with total annual incomes of less than $20,000. Medicaid was the most common source of payment for CMHC services, although the consumer's family was the direct source of payment for a large percentage (29%) of youth without SED.

Among youth with SED, primary diagnoses of disruptive behavior, attention deficit, anxiety, and mood disorders were most common, accounting for 83% of the youth. By contrast, among consumers without SED, the most common primary diagnosis was adjustment disorder (27%). Disruptive behavior, attention deficit, and mood disorders were also very common, accounting for an additional 44% of youth without SED.

Service Needs

In order to identify gaps in service capacity, the total amount of individual services recommended was compared to the total amount received. The CMHCs were able to meet a substantial amount of estimated need for inpatient and medication management for consumers with SED (greater than 90% and 80%, respectively). For consumers without SED, estimated need for inpatient and highly intensive residential services was most frequently met (greater than 70%). With respect to gaps, the largest gaps for youth with SED were found for in-home supported living, day treatment, and residential support where less than 50% of recommended services were received. For youth without SED, the largest gaps were found for residential support, in-home/supported living, rehabilitation, day treatment, and early intervention; less than 30% of the total estimated services needed were provided.

Reasons for Gaps

The reasons for insufficient amounts of services being provided were consistent regardless of SED status. "Lack of capacity" was the reason reported for the greatest percentage of youth not receiving needed services. "Missed/no show" and "consumer/family decision" were also significant factors, particularly for outpatient and medication management services. For this latter service category, "consumer/family decision" was the most frequently occurring reason. Other reasons, cited only rarely, were "consumer behavioral problems," "insufficient consumer resources," and "inaccessibility."

Cluster Analysis

The cluster analysis was limited to consumers who responded to the Virginia Service Assessment Questionnaire and Continuum of Care Consumer Profile. The final data set included 1097 youth with SED and 799 non-SED youth. Because the number of youth with SED were not in proportion to the number of non-SED youth, the non-SED proportion to the number of non-SED youth, the non-SED sample was weighted by 1.67. This weight was derived from the percentage of SED cases in the sample weighted by geographic location. This resulted in a total sample for the cluster analysis of 2428 youth.

In order to classify consumers according to the service packages recommended by case managers, a cluster analysis using the K-means procedure of the Statistical Package for Social Sciences (SPSS) was conducted. Cluster solutions using 3, 4, and 5 clusters were computed in an effort to identify the solution which created clusters with sufficient sample sizes (N > 30) to allow for further data analysis and ease in interpretation. Using this criterion, the four cluster solution was chosen as the preferred solution for services recommended.

Using cluster membership as the independent variable and number of service hours per service type as the dependent variable, a one-way analysis of variance (ANOVA) was used to identify those service types that distinguished among the clusters. When the F-score for a given service type was found to be statistically significant, the Student-Newman-Keuls procedure was used to differentiate among clusters on that service (see Table 1).

To interpret the clusters, attention was given to those services shown by the post-hoc analysis to most clearly distinguish each cluster from the other clusters. Individuals in Cluster 1, labeled Residential Services, needed the most units of intensive residential services and outpatient services. The most characteristic feature of Cluster 2, which described over 90% of the sample, was the low rate of all services recommended. Therefore, this group was labeled Minimal Services. Individuals in Cluster 3, labeled Inpatient Services, were described as needing the highest rates of inpatient, residential, and case management services. Individuals in Cluster 4 were recommended for the widest variety of services with need for residential support, day treatment, and vocational services exceeding that of the other groups. These services are primarily community based and of moderate intensity, and therefore, this cluster was labeled Wraparound Services. The stability of the cluster solution was confirmed by selecting random subsamples and repeating the cluster procedure on the subsamples to test for consistency of the cluster memberships between the full sample and subsamples using the Kappa statistic.

Discriminant Function Analysis

To determine which demographic variables could predict cluster membership, a discriminant function analysis was conducted using the Wilk's lambda method to test for the discriminating power of the variables in the function. Given the absence of a priori knowledge about the distribution of group membership, the equal prior probabilities method was used. The variables that predicted cluster group membership

based on services needed are presented in Table 2. Classification of cases to clusters based on these variables made 61% fewer errors than would be expected by chance. In order to determine the relationship of these variables with cluster membership, a one-way analysis of variance was conducted using cluster membership as the independent variable and the predictor variables as the dependent variables. All of the predictor variables were significant (p <.01). Finally, the Student-Newman-Keuls test (p < .05) was used to determine the significance of differences between the group means.

These findings indicate that children perceived as needing Inpatient Services (Cluster 3) are more likely to be in special education, have a thought disorder diagnosis, have a history of previous mental health hospitalization, and have a low GAF score, indicating high impairment. Youth needing Residential Services (Cluster 1) were more likely to have an involuntary referral from the criminal justice system, a diagnosis of substance abuse, and a relatively high GAF score, indicating low impairment. Non-SED children living in a private home were most likely to be perceived as needing Minimal Services (Cluster 2). There were no clear predictors of membership in Cluster 4, Wraparound Services.

Discussion

Overall, the results of this study indicate that in Virginia's public mental health system:

- The greatest needs are for increased service capacity for residential and day support services.
- In the opinion of direct service staff, lack of service capacity is the major reason why consumers do not receive the amounts of service needed.
- Youth who are recommended by clinicians/case managers to receive more intensive services fall into three groups based on typical service packages recommended (i.e., inpatient, residential, and wraparound).
- Several demographic and mental health variables can be used to predict which youth will be most likely to use a particular "service package." These variables include score on the GAF, history of mental health hospitalization, diagnosis, SED status, special education status, legal status, and residence in a private home versus other living arrangement.

The results of this study provide documentation of the greatest service needs for child/adolescent consumers of public mental health services within one state system. There appears to be a large unmet need for all types of community-based services, and a need for CMHCs to be able to offer a broader array of services than they currently offer. The results of this study are being used to support and develop a "reinvestment strategy" (i.e., moving funds from inpatient to community-based services) as well as managed care-type initiatives.

The youth typologies and related service packages can provide a useful tool for service systems planning. Knowledge of appropriate service packages for different types of youth will allow planners to "size" the system of care based on the known characteristics of the consumer population. Since there are differences in the variables that predict service usage between youth and adults, examining these populations separately is likely to result in more accurate estimations of service utilization.

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The Individualized Needs for Service Assessment (INSA) for Children with Serious Emotional Disturbances

Authors

Background & Significance

This summary reports on efforts underway in New York State to develop the Individualized Needs for Services Assessment (INSA), a set of standardized procedures and data definitions to guide assessment of service needs for children with serious emotional disturbances (SED). The INSA is intended to be used by: (a) service providers and family members who want to develop individualized service plans; (b) planners and policy makers who want to quantify need for services at the community level, and services researchers who want to study factors correlated with service needs; and (c) managed care organizations and purchasers of services who want to balance issues of ensuring access to needed services while reducing provision of unnecessary, ineffective, or overpriced services.

A major challenge confronting the mental health field is to operationalize and quantify the concepts of need and unmet need for services (Klerman, Olfson, Leon, & Weissman, 1992; Bebbington, 1990). Policymakers, service providers, and advocates for children with emotional disturbances consistently place a high priority on the provision of sufficient services to meet what are perceived to be high unmet needs for services. Methods for detecting and diagnosing emotional disorders in children have improved and become more standardized. However, there are no standardized procedures either for determining which services are needed in individual cases or for specifying the community service capacities needed to serve diagnostically defined subpopulations.

Assessment of service needs is complicated by the fact that children with SED frequently are served by multiple provider systems. Needs typically have been defined in terms of organizational settings or program components, such as residential treatment facilities, clinics, or day treatment programs (Burns, Angold, & Costello, 1992; Pires, 1990). Yet, a program component approach does not clarify what service items are needed and makes it difficult to measure the extent to which service needs are met by other systems of care that may deliver similar services but use incompatible terminology. It also creates problems in applying findings from one geographic region to another, where services may be organized differently, or for designing new forms of service organization that would be more efficient in meeting needs.

Individualized Service Planning

The federal Child and Adolescent Service System Program (CASSP) initiative identified children with SED as a high priority, given that many of them are underserved and in need of advocacy, while others are treated, often ineffectively, in costly inpatient settings and other out-of-home placements (Stroul & Friedman, 1986). CASSP selected the following as basic parameters for defining the population of children with SED: (a) impaired social functioning in family, school, and neighborhood contexts; (b) in need of a range of services requiring the involvement of multiple agencies including the mental health, health, education, child welfare, juvenile justice sectors, and others; and (c) impairment that has lasted or is expected to last one year or more. CASSP envisioned a child-centered, community-based system, providing a comprehensive array of services including mental health, social, educational, health, vocational, recreational, and operational components (Stroul & Friedman, 1986).

Recent literature has placed emphasis on principles that lay a foundation for services that are (a) flexible and accommodate the individual needs of the child and family, (b) family-focused and involve the family in planning, and (c) competent and meet the needs of multi-cultural populations (Duchnowski & Friedman, 1990; Duchnowski & Kutash, 1993; Katz-Leavy, Lourie, Stroul, & Zeigler-Dendy, 1992). CASSP envisions the development of individualized service plans as a critical aspect of practice within a comprehensive system of care and that should have a strong bearing on what services a child and family ultimately receive (Burchard & Clarke, 1990; Duchnowski & Friedman, 1990; Duchnowski & Kutash, 1993; Katz-Leavy et al., 1992; Rivard, Perry, & Hinkle, 1994). With the growing programmatic emphasis on individualized service approaches &emdash; based on the principles of unconditional care, family involvement, multi-cultural competence, delivery in a child's natural environment, and tailoring to the individual needs of the child and family &emdash; knowledge about appropriate assessment of individual service needs is sorely needed.

The growing emphasis on managed care to control access to and coordinate services places additional importance on the development of a consensus within the child mental health field of what constitutes service need. Under traditional financing arrangements and multiple, uncoordinated delivery systems, there was little incentive to reduce costly or inappropriate provision of services for children who had access. The broad coverage and capitation financing arrangements envisioned under managed care will provide strong incentives to limit or deny care when services are judged as unnecessary. In the absence of guidelines for what constitutes need, the impact of managed care on children with SED may place children at even greater risk for under-provision of services.

MRC Needs for Care Assessment Approach

While the Medical Research Council (MRC) Needs for Care Assessment Procedure was developed for adults with psychiatric disabilities (Brewin, Wing, Mangen, Brugha, & MacCarthy, 1987; Mangen & Brewin, 1991; Brewin, 1992), it provides concepts, procedures, and a logic structure that we have adapted for assessing the service needs of children with SED. Needs are defined according to an assessment of functioning that includes domains related to psychiatric symptoms and social role performance. Generic service items (defined independent of program components) are listed under each functional domain where they are considered likely to be effective.

For any particular individual, need is defined according to assessment of functioning, the effectiveness that a particular service item is expected to have for this particular individual, and the acceptability of the service item to the individual. The procedure includes a logic structure that leads from judgments in these three areas to categories of need for each domain and each service item. In addition to results ranging from unmet need, partially met need, and met need, the procedure allows for ratings of no meetable need (i.e., when no interventions are judged to be effective and acceptable to address a domain problem for a particular individual) and overprovision (i.e., when the frequency or intensity of a service item exceeds what is required to achieve functional outcomes).

Process

The INSA procedure for children with SED is designed to be consistent with principles from CASSP and individualized service planning and applies data standards and a logic structure adapted from the MRC Needs for Care Assessment. The INSA is being further specified and tested in The SED Study, an National Institute of Mental Health (NIMH)-funded child mental health services research study being conducted by Columbia University (Christina Hoven, Principal Investigator) in Westchester County as well as in The FRIENDS Project, a Center for Mental Health Services (CMHS)-funded comprehensive services demonstration in the Mott Haven section of the Bronx.

Interdisciplinary Teams with Family Participation

In both settings, service needs are being assessed using interdisciplinary teams with the participation of family members. In Mott Haven, for example, once a child is found eligible for FRIENDS (based on criteria for SED), a team is assembled to develop an individualized service plan. Team members include parents or surrogate parents, the child (as appropriate), and representatives from the mental health and education systems. Representatives from child welfare, juvenile justice, alcohol substance abuse, primary health care, recreation, and other relevant programs or community organizations also may be included. Information about providers previously or currently serving the family or expected to serve the family in the future is considered in selecting team members.

The team reviews the thorough clinical and functional assessment conducted as part of the FRIENDS admission process, along with historical records, and gathers any additional information required for the needs assessment. Team members complete INSA forms individually, and then the team discusses each component of the assessment with the goal of achieving consensus on all phases. The team's INSA results represent what the child needs ideally. This information is then used by the team to develop an individualized service plan that factors in how services can best be delivered given real-world constraints of availability, organization, and financing of existing services. Analyses comparing INSA results with individualized service plans will be conducted to support community planning and funding allocation. For the Westchester study, a similar process is being undertaken, incorporating an expert, multi-disciplinary panel into the research process.

Data Standards and Logic Structure

Functional Domains

Functioning is assessed for the following domains: (1) self-care; (2) family life; (3) social and interpersonal relationships; (4) learning, school performance, vocational relationships; (4) learning, school performance, vocational development; (5) disruptive behavior; (6) mood symptoms; (7) anxiety symptoms; (8) symptoms of psychosis; (9) attention deficit and/or hyperactivity symptoms; and (10) alcohol and/or other substance abuse. The child's functioning in each domain is rated according to a four-point scale from no problem to severe. Additional instrumentation is in development to support functional ratings responsive to the child's developmental stage.

Service Items

The INSA approach incorporates a taxonomy of over 75 generic service items thought to be capable of meeting need. "Generic" refers to service items that are generalizable and comprehensible across different organizational units and systems of care. Examples include:

- psychotherapy, brief or short-term individual, for the child;
- home-based training in parenting skills, child behavior, and symptom management for parent(s) or family members; and
- peer support, self-help, or support group for the child.

For each functional domain, service items thought likely to be effective according to expert judges are listed. Some service items appear under multiple domains. For those functional domains where the child is experiencing problems, team members rate service provision according to a scale that takes into account both current and past receipt of the service item.

Anticipated Clinical Effectiveness

The team rates the anticipated clinical effectiveness of each service item in addressing problems the child is experiencing in a given domain according to the following scale: (0) demonstrated ineffective with adequate trial; (1) no adequate trial, but judged to be ineffective; (2) no adequate trial, but believed to be effective or partly effective; (3) partly effective based on adequate trial; (4) demonstrated effective based on adequate trial; (8) inconclusive, judgment deferred; (9) not applicable. These judgments incorporate knowledge found in the professional literature (e.g., outcome studies, practice guidelines) as well as factors specific to the individual, such as service history.

Child and Family Acceptability of Services

The team rates the level of acceptability of the service item to the child and family according to the following scale: (0) rejection; (1) not likely to be acceptable; (2) likely to be acceptable; (3) demonstrated to be acceptable; (8) uncertain; (9) not applicable. This rating is made considering the family's prior experience with similar approaches, cultural appropriateness, and other factors related to individual preferences.

Need Status

Need status is measured according to the following scale: (0) no need, (1) no meetable need; (2) unmet need for assessment/trial; (3) unmet need for provision; (4) met need, maintain current frequency/intensity; (5) met need, increase frequency/intensity; (6) met need, assess overprovision. In addition, a judgment as to the presence or absence of overprovision is made when indicated. A logic structure that considers the ratings made on the above dimensions either determines the rating on need status or narrows the response categories available for any given rating. For example, a service item with an acceptability rating of rejection or a clinical effectiveness rating of ineffective would lead to a need status of no meetable need. A computerized version of the needs assessment, that automates the logic structure, is being planned.

Discussion

The INSA approach offers a standardized set of methods for assessing the service needs of children with SED that may be applied to individualized treatment planning, managed care, services research, and community planning. When aggregated across individuals, need may be studied on at least three levels: (1) global measures of need and unmet need, such as whether any unmet need is present or the number of items with unmet need; (2) functional domains, such as what factors are associated with unmet need for services designed to address disruptive behavior; and (3) individual service items, such as factors associated with need for behavior therapies. Over time, the INSA will be adapted to incorporate new knowledge about service strategies and effectiveness.

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Assessing Need and Planning for a System of Care in a Culturally Diverse Urban Community

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Introduction Method & Results Discussion References

Introduction

There is a growing urgency to develop community-based systems of care for children with serious emotional disturbances as the nation moves to provide mental health services in less restrictive and less costly living environments than those provided in institutional settings. In many communities across the country, ethnic minority children represent a significant proportion of the child population. The challenge is to find ways of incorporating these children into service delivery systems that are more culturally sensitive to them.

In response to a call for a framework that would guide the development of community-based systems of care, Stroul and Friedman (1986) proposed that "emotionally disturbed children should have access to a comprehensive array of services" (p. 18) coordinated across human service agencies such as education, social service, health, and juvenile justice. Cross, Bazron, Dennis, and Isaacs (1989) added that "when the system of care functions as an integrated support network" (p. 53), it supports and enhances the delivery of culturally competent services. In an integrated support network, the chances of considering the needs of both ethnic minority and ethnic majority children are likely to be much higher than in a fragmented and duplicative system. Cross et al. (1989) further suggested that those making plans for culturally competent systems of care need to be aware of the resources, available inside and outside communities, which can promote change. Some communities have a wealth of resources that allow them to develop home-grown, self-sustaining, and culturally competent systems of care, but many communities must rely on outside resources to sustain and enhance their own culturally competent care systems.

Study 1 of this summary provides an assessment of need for children's mental health services in the Mott Haven community of the South Bronx. Such assessment will be used as a baseline of the need for a community-based system of care currently being developed through the Families Reaching in Ever New Directions (FRIENDS) Initiative, a five-year project funded by a grant awarded by the federal Center for Mental Health Services. The assessment will seek to answer the following questions:

- What is a reasonable estimate of need for children's mental health services?
- What is the current utilization of children's mental health services?
- What is a reasonable estimate of the cost of mental health services currently being utilized?

Study 2 describes the cultural, personal, and service utilization characteristics of Mott Haven children who are recipients of existing mental health services through a correlational analysis. Such description is viewed as important to planning for a system of care in a culturally diverse community that is 67% Hispanic, 31% African American, and 2% Caucasian. The analysis will address the question: To what extent are the cultural and personal characteristics of Mott Haven children related to the children's utilization of mental health services?

Method and Results

Study 1

The New York State Office of Mental Health (NYSOMH, 1992) has developed a population-based approach to estimate the need for mental health services for children in specific communities across the state. This methodology resulted in estimates of the number of children needing services during a typical week of the year for each of seven types of mental health programs (acute inpatient and crisis residential, home-based crisis intervention, intermediate inpatient, residential, school-based clinical, intensive case management, and clinical). Low, average, and high need for capacity rates per 100,000 children in the population were generated based on geographic differences. The high rate was applied to the child population of Mott Haven because of the presence of the many environmental risk factors that are believed to exacerbate the mental health conditions of the children. The first column of Table 1 shows the estimate of needed capacity for each of the seven types of mental health programs. As indicated, a system of care in Mott Haven would need to serve at least 467 children on a continuous basis. These children represent 1.4% of the population of 32,793 children and youth residing in Mott Haven. This is consistent with Friedman's (1987) estimate that a public system of care should have a capacity to serve between 1 to 2 percent of children at any given time.

Second, the above estimate was compared to the actual utilization of mental health services by Mott Haven children and youth during a one-week period in 1993, as reported in the Patient Characteristics Survey of the NYSOMH. As the Patient Characteristics Survey of the NYSOMH. As seen in the second column of Table 1, only 160 children and youth, or 34% of the estimated number of children who need mental health services, utilized those services.

Third, Table 2 reports cost estimates for each of the seven types of mental health services per unit of utilization, for total units utilized, and for an entire year. The figure of $4,234,932 provides an estimate of the total annual cost of sustaining a comprehensive array of services for children and youth ages 21 and younger in the Mott Haven community.

Study 2

Plans to develop a culturally competent system of care are enhanced by information on how cultural and personal characteristics of children with mental health needs relate to the children's utilization of mental health services. Such relationships were explored among a sample of 143 Mott Haven children and youth ages 17 and under who utilized mental health services during a one-week period in 1993. Measures of cultural and personal characteristics included Ethnicity (African American = 1, Hispanic = 2), Primary Language (English = 1, Other language = 2), Age Group, defined as eight age categories between 0 to 17, and Gender. Children's service utilization was measured through Program Type (Outpatient = 1, Inpatient = 2), Clinic Visits, with a 0 to 2 range, Day Treatment Visits, with a 0 to 5 range, and Location (inside or outside Mott Haven). The measures of visits to clinic and day treatment programs were selected because clinic and day treatment were the services to which Mott Haven children had the greatest access.

Table 3 shows Pearson correlations between the measures of cultural and personal characteristics and the measures of children's service utilization. Ethnicity had a relatively strong negative relationship with Location indicating that African American children had a tendency to receive services outside Mott Haven, while Hispanic children tended to be served inside Mott Haven. Primary Language had a moderate negative relationship with Location. Since Spanish was the primary language for many of the children, the finding suggests that these children had better access to mental health services within Mott Haven rather than outside Mott Haven. Ethnicity and Primary Language were weakly and positively related to Clinic Visits suggesting a tendency for Hispanics and persons speaking Spanish and other languages to visit clinics more often than African Americans. Finally, there was a weak negative relationship between Age Group and Clinic Visits suggesting that younger children are more likely to visit clinics than older children. Among possible explanation is that older children and youth may view visits to a clinic as potentially stigmatizing.

Discussion

Discussion

Study 1 in this paper suggested the utility of applying a population-based approach to estimating the need for a comprehensive array of mental health services for children with mental health needs in an urban community such as Mott Haven. The estimate of need for services in Mott Haven was compared to the children's actual use of services showing that there may be a large gap between the need and the use of services. An estimate of the cost of providing mental health services to Mott Haven children in 1993 was possible given the availability of information on the children's use of services. The long term benefit of having a baseline estimate of mental health service costs is that it will make it possible to compare it with an estimate of costs after a new system of care for children has been implemented through the FRIENDS Initiative. At such time, it will also be possible to determine whether a new system of care reduces or increases costs of serving children with mental health needs in an urban community.

The findings in Study 2 provide some support for using personal characteristics and cultural measures to better understand patterns of service utilization in culturally diverse urban communities. It was particularly interesting to see the extent to which children from African American and Hispanic backgrounds appeared to use mental health services differentially inside and outside Mott Haven. Such finding suggests the need to develop a fuller understanding of the cultural factors that mediate the differential use of services by children with mental health needs.

Estimating service needs, determining rates of service utilization, estimating service costs, and understanding personal cultural factors that mediate service use are all important components in planning systems of care for children with mental health needs that are also culturally competent. This study serves as a starting point for describing the relationship between these indices.

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Chapter 11

Instrumentation & Methodology

Principles for Conducting Outcomes Research

Authors

Introduction
Principles to Consider when Planning Outcomes
Principles to Consider when Interpreting Outcome Results
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Shortcuts

Introduction

Outcomes data have increasingly become a meter by which mental health services are evaluated. This is particularly the case in this age of managed care, and calls for accountability in service delivery where providers are asked to justify services on the basis of client outcomes. Outcomes data also are crucial for quality assurance and continuous quality improvement efforts, as embodied in concepts such as outcomes monitoring and outcomes management. However, while the movement toward outcome monitoring should be applauded, evaluation efforts involving outcomes should not be naively undertaken. Service providers, administrators, and evaluators should seriously consider a number of important theoretical and research issues that can limit conclusions made from outcomes data and research studies. A number of principles should be considered when planning outcome studies and especially when interpreting research results.

Principles to Consider when Planning Outcomes

Recognize that "outcome" refers to multiple rather than a singular domain.

The word "outcome" has been used many times without outlining what is actually meant. A vague use of the term seems common. Multiple outcomes are generally acknowledged, but the apparent lack of specificity when discussing outcomes suggests a need for further conceptualization.

Hoagwood, Jensen, Petti, & Burns (in press) developed an excellent conceptual model of outcomes that attends to multiple levels (e.g., individual, family, and community) and contexts (e.g., home, school, and peer group). Their model consists of five domains: (a) symptomatic/diagnostic (e.g., depression, aggression, and diagnosis); (b) functional (e.g., child's adaptation to various environments); (c) consumer perspectives (e.g., client satisfaction and family's quality of life); (d) environmental (e.g., changes in marital relationship or school environment); and (e) services and systemic (e.g., reductions in out-of-home placements, hospitalization rates, and length of stay).

I would add one additional outcome domain&endash;protection of child and family rights and dignity. This domain would include no harm occurring to the child or family during treatment, maintenance of confidentiality, provision of effective services, and outcomes associated with consumer empowerment, such as opportunities for family involvement in developing agency policies and services as well as family involvement in treatment, especially a significant "voting" role in treatment decisions.

Choose outcome domains that coincide with the program theory.

It is important to select outcome domains that match the service program being evaluated. What outcomes would you reasonably expect to be associated with an adequate implementation of your program theory? What additional outcomes would your program like to meet?

This principle became particularly clear as a result of some work recently done by the author to define quality indicators with an agency that provides services to children and adolescents who have had significant contacts with the juvenile justice system. They were asked to list crucial elements associated with producing positive clinical outcomes. The first question asked was what was meant by clinical outcomes, as they recently had problems developing a shared understanding of this term in a meeting with a managed care company. This agency recognized that they might not be able to significantly impact clinical symptoms in their programs, but hoped to have an impact on functioning, especially societal, school, and vocational functioning, especially societal, school, and vocational functioning. They also were very concerned with creating a safe environment (i.e., protecting client rights) for those in their program.

Principles to Consider when Interpreting Outcome Results

The source of information should be considered when reflecting on outcome results.

Constructionist theories suggest that each individual has their own unique perspective on the world. Truth is truly in the eye of the beholder. In the case of collecting outcomes data, it seems important to consider how different sources (e.g., parents, clinicians, children, and teachers) may contribute different information. Many possibilities exist that might explain why we would obtain different outcome results from different sources, including: (a) each source has a different sample of a particular child's behavior from which to make outcome judgments, and (b) points of reference for making judgments differ.

In regards to the first reason, parents may be good reporters of some behaviors, but may be less aware of certain aspects of their child's life. For example, the amount of information a parent has about a child's school and social life may vary considerably. The level of parent involvement would affect the validity of parent reports in these areas. Another area of interest concerns the validity of reports of externalizing and internalizing behaviors. Parents are generally thought to be better reporters of externalizing behaviors, because they are more likely to come to their attention. Adolescents are viewed as better reporters of internalizing behaviors. Teachers may provide valid reports of academic and social behavior, but fewer valid reports for other behaviors. Service providers likely have very limited knowledge of the child's behavior outside of the service setting.

In addition to interacting with the child in different contexts, different sources of information likely have different points of reference from which to make their judgments. In other words, the sample to which the child is being compared for making judgments is likely to differ. Response categories on various scales (e.g., somewhat or sometimes true, a lot or a little, more than average or less than average) may have different meanings to different judges. For instance, teachers are very familiar with a wide-range of children and may have a different sense of what "average" or "a lot" mean, compared to parents and clinicians.

Recognize that clinical outcomes are not solely the result of services.

Multiple factors impact the mental health of children. These include family influences, peer influences, cultural influences, economic influences, and strengths and resiliency. These factors must be considered as additional resiliency. These factors must be considered as additional influences on changes in symptoms and functioning that occur between intake and exit from services. In a review of research on the impact of disasters on the psychological health of adults and children (Salzer & Bickman, in press), one consistent finding is that disasters are associated with high levels of psychological distress immediately following the traumatic event. However, as the community and families recover, usually without the aid of mental health interventions, psychological problems remit. One explanation for these results is based on a central tenet of ecological theories&endash;natural systems work to return to stasis following a disruption.

Children and families entering services do so at a time of great upheaval and are generally found to be improved at the end of treatment. However, the role of services in bringing about such changes often fails to be separated from non-treatment effects. The natural resiliency and resources of children and family systems likely contribute to improvements over time. Children and families, either consciously or unconsciously, work to make changes that alleviate stressors, with and without help from service providers. Children, parents, and other family members also rely on their natural resources, such as friends and other family members, in addition to the support and guidance provided by the service system. The fact that even non-treatment control groups may improve over time supports the notion that natural recovery processes are important factors to consider when making causal statements about the relationship between treatment and improvement.

Use of control groups would be one obvious approach to take in order to distinguish between natural recovery processes and treatment effects. The development of long-term norms on various measures for those with severe problems who have not received services might be another approach. The clinical outcomes for one child, gathered at 6-months post-intake, could be compared to the 6-month norms for children who also scored high on the same instrument at time 1 but received no treatment.

Adequate statistical power and appropriate procedures are necessary when analyzing data.

Statistical conclusion validity (Bickman, 1990) is a significant problem with current research on outcomes associated with measures of mental health. Statistical conclusion validity refers to the researchers' ability to make valid statistical conclusions, including the ability to detect an effect when one is present (i.e., power) and when one is not present (i.e., Beta or type II error). One concern is that many studies lack sufficient statistical power to detect small or medium effect sizes, due to small samples. This may, in fact, account for some of the null results and inconsistent results reported in the literature for various interventions.

While it depends on the effect size that one expects to be associated with the intervention, in general, researchers should strive for large sample sizes whenever possible.

While lack of statistical power may limit the number of studies finding positive effects for community interventions, a great number of studies also include multiple, unplanned statistical analyses that inflate the familywise error rate to such an extent that erroneous conclusions might be made suggesting an intervention is effective when it may not be (i.e., alpha or type I error). For example, it appears common for researchers to conduct multiple univariate tests without the proper corrections for inflated alpha levels.

Conclusions are limited by the outcome domains you choose.

Results from one outcome domain cannot be used as a proxy for other domains. This is a particularly important concept to keep in mind when attempting to assess the clinical effectiveness of services, without obtaining data on clinical symptoms or functioning. For example, reductions in service utilization, such as the number of out-of-home placements or decreased rates of hospitalization, may be reported to imply that a service system or a particular service like case management are clinically effective. However, service utilization outcomes may predominantly reflect modifications in system priorities and policies regarding level of care or length of stay decisions rather than actual changes in the child's behavior (e.g., one of the philosophies associated with a system of care places an emphasis on keeping children in their homes, or at least their home communities, and this philosophical change alone may account for decreases in out-of-home placements and hospitalization rates regardless of changes in the child's behavior). While extremely important, service utilization outcomes are of little benefit in evaluating the clinical effectiveness of a system of care.

There appears to be another current trend toward reporting services to be effective based on results from consumer satisfaction instruments. Consumer satisfaction is vitally important to how services should be evaluated, but the relationship between satisfaction and clinical outcomes is unclear (Lambert, Salzer, Bickman, 1996). The best way to assess clinical outcomes may be through the use of measures assessing symptoms and functioning.

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Symposium:

Symptoms and Functioning: Service Implications of Recent Research on Serious Emotional Disturbance

Authors

Introduction Origin, Meaning and Use Service Needs Validity

Shortcuts

Introduction

E. Jane Costello

Recent changes in regulations governing access to mental health care resources for children have included requirements that children not only have a psychiatric disorder but also be functionally impaired. This has aroused interest in the concept of functional impairment or adaptive functioning (i.e., its history, measurement, and significance as an indicator of need for services). In this symposium, (a) Dr. Horwitz traces the history of the concept, (b) Dr. Costello describes its prevalence and correlates in the community, and (c) Dr. Angold discusses evidence for impairment as a marker of service need.

The Origin, Meaning and Use of Adaptive Functioning in Defining Mental Health Problems

Sara M. Horwitz, K. Hoagwood, S. S. Sparrow & E. Triche

The concept of adaptive functioning grew out of the study of mental retardation. Concerns with decreased intellectual functioning became important because of increased societal demands brought on by industrialization, urbanization, and universal public education. Early work around quantification of intellectual abilities revealed variations in functioning not uniformly related to intellectual levels. These differences in functioning were related, however, to an individual's ability to perform age-appropriate social roles and became incorporated into the definition of mental retardation. For those with severe and persistent mental illness, the need to differentiate individuals with respect to prognosis and services planning led to an interest in adaptive functioning and its eventual inclusion in the multiaxial classification system of the Diagnostic and Statistical Manual (DSM), 3rd Edition. Unfortunately, measurement of adaptive functioning within the definition of mental disorders is underdeveloped and has been confined largely to a single global measure of functional impairment.

Service Needs and Use for Serious Emotional Disturbance: A Community Study

E. Jane Costello

Many federal and state agencies and insurance companies are adopting the federal definition of Serious Emotional Disturbance (SED) as the criterion for child psychopathology of sufficient severity to require services. SED is defined as a DSM-defined psychiatric disorder resulting in functional impairment that substantially interferes with or limits the child's role or functioning in family, school, or community activities.

Methods

In the Great Smoky Mountains Study, we examined the prevalence of SED in a representative population sample of children age 9 - 13, randomly selected from a largely rural area of the southeastern United States. Interviews with 1,015 parent and child pairs were conducted by trained interviewers using (a) the Child and Adolescent Psychiatric Assessment (CAPA) which assesses DSM-III-R disorders and functional impairment, and (b) the Child and Adolescent Services Assessment (CASA) which records service use across five service sectors (i.e., specialty mental health, education, primary care, juvenile justice, and child welfare). Functional impairment was also evaluated using the Children's Global Assessment Scale (C-GAS) and the North Carolina Child and Adolescent Functional

North Carolina Child and Adolescent Functional Assessment Scale (CAFAS). Prevalence estimates were adjusted for design effects.

Results

Of the 20.3% of the population who had one or more DSM-III-R disorders, 55% (11.1% of the population) met criteria for SED according to one or more of the three measures of impairment used (i.e., CAPA, C-GAS, or CAFAS). Boys and girls were equally likely to have SED. Of children in the sample with conduct disorder, 78.8% had SED, compared with 73.4% of those with depressive disorders, 91.3% of those with oppositional defiant disorders, and 73.1% of those with ADHD. Disorders least likely to be associated with functional impairment were anxiety disorders (45.8%), tics, and functional enuresis (32.6% each).

Children with SED used services at a higher rate than those with only a DSM diagnosis or only functional impairment. However, the majority of children with SED had received no mental health services from any service sector during the three months preceding the interview. Of children with SED, 19.2% had received services in the specialty mental health sector, 29.1% in the school system, 6% from primary care providers, 5.3% through child welfare agencies, and 2% through juvenile justice. In total, only 37.7% of children with SED received mental health care from any agency, compared with 6% of children with only a DSM diagnosis or functional impairment.

Conclusions

Use of the SED criterion will identify around one child in ten in the population, depending on the criteria used. These youth are much more likely than children with less severe symptoms to receive mental health care; however, only about one in three is currently receiving any form of care. Thus, adopting SED as the definition of need for care identifies a large gap between need and availability of services.

The Validity of Serious Emotional Disturbance as a Marker for Need for Services

Adrian Angold

The addition of functional impairment to diagnosis as a criterion for eligibility for various treatment and reimbursement programs reflects an attempt to focus scarce resources on those in greatest need. In this paper we explore some empirical evidence testing the hypothesis that children with SED have greater service needs than children with (a) functional impairment associated with psychiatric symptoms but no specific DSM diagnosis, (b) children with impaired functioning but few or no psychiatric symptoms,

(c) children with a DSM disorder but no functional impairment, or (d) children with neither psychopathology nor impairment.

Method

The Great Smoky Mountains Study's representative population sample of youth aged 9 - 13 (N = 1,015) was used for these analyses. Psychiatric symptoms were assessed by trained lay interviewers using the Child and Adolescent Psychiatric Assessment (CAPA), and service use across five service sectors was recorded using the Child and Adolescent Services Assessment (CASA). Service need was defined in the following ways: (a) use of specialty mental health services; (b) use of school counselors and school psychologists for emotional and behavioral problems; (c) parental report of economic, social, or psychological burdens associated with the child's symptoms; (d) report by parent or child that the child had a problem in one or more symptom areas; and (e) report by parent or child that help was needed because of such a problem.

Results

Children with SED had the highest rates of use of specialty mental health and school services, the highest rates of burden, reports of problems, and need for help. However, children with functional impairment, with or without some psychiatric symptoms, were more likely than children with a DSM-III-R diagnosis but no functional impairment to meet the various criteria of need for services. Between the first and second years of the study, there was a considerable amount of movement between categories for severity of disorder.

Conclusions

While the combination of a DSM diagnosis and functional impairment (SED) identifies children with high levels of need for services, service needs are also high in youth with less severe psychopathology but marked functional impairment. If these children are excluded from access to care because agencies adopt SED as the criterion for access to care, many children in need will be excluded. Furthermore, it will exclude from services children with less severe symptoms but high levels of functional impairment who are likely to move into full-blown SED without treatment.

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Quality as Relationship Between Structure, Process, and Outcome: A Conceptual Framework for Evaluating Quality

Authors

Introduction
The Holy Trinity of Structure, Process, and Outcome
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Introduction

Consumers, providers, and policymakers all have called for the monitoring of quality in order to ensure that lower costs do not mean low-quality care. The assessment of quality is also a significant element of the continuous quality improvement movement, a movement that is crucial for improving mental health services.

Three circumstances inhibit meaningful monitoring of quality of care in children's mental health. First, the indicators compiled to date do not extensively cover all quality domains. Second, research on quality of care in children's health services is conspicuously lacking (McGlynn, Halfon, & Leibowitz, 1995). Third, the concept of quality of care is underdeveloped to the extent that current approaches to monitoring quality may fail to assess the "goodness" of delivered services. This summary focuses on the last concern.

The Holy Trinity of Structure, Process, and Outcome

Most approaches to evaluating quality are based to some extent on Donabedian's tripartite model of quality. This model addresses three domains: structure, process, and outcome (Donabedian, 1980). Structure refers to "the relatively stable characteristics of the providers of care, of the tools and resources they have at their disposal, and of the physical and organizational settings in which they work" (Donabedian, 1980, p. 81). Five structural categories are thought to be important in assessing the quality of service structure: (a) Access; (b) Institutional Characteristics; (c) Provider Characteristics; (d) Community Characteristics; and (e) Client Characteristics.

Process focuses primarily on treatment process, including interpersonal process factors and technical skill in the delivery of services. Interpersonal process refers to the therapeutic relationship and rapport, communication, information dissemination, and shared decision-making that occur as part of treatment. Technical skill encompasses knowledge of state-of-the-art intervention techniques, the ability to assess which intervention provides the best match for the client's problems or diagnosis, and the skill to effectively deliver the best matching intervention.

While Donabedian and other quality-of-care theorists focus on technical and interpersonal factors in understanding process, additional quality process categories should also be considered. Stages-of-treatment-process indicators concern the quality of intake and assessment, treatment planning, service utilization (e.g., # of sessions/service units, length of treatment, and service patterns), and appropriate termination. Service process can also refer to barriers to treatment, timeliness of treatment, accountability to consumers, consumer advocacy, and protection of client rights.

The last component of quality is outcome. Donabedian (1980) defined outcome as "a change in the patient's current and future health status (symptoms and functioning) that can be attributed to antecedent health care" (p. 82). Donabedian also included patient attitudes about treatment, such as patient satisfaction, health-related knowledge, and behavioral change in areas that contribute to health problems. Protection of child and family rights and safety can also be added as another important outcome category. This would include the maintenance of confidentiality, the utilization of least restrictive services, and the right to receive services known to be effective.

Approach to MonitoringQuality of Care

One basic concept appears to underlie all approaches to monitoring quality of care: that quality can be examined by assessing any one of its three components. This concept is assessing any one of its three components. This concept is consistent with Donabedian (1980), who considered the evaluation of structure, process, or outcome as all providing a similar picture of quality of care. Three approaches have been taken to assess quality of care: the use of standards and guidelines, peer review, and outcomes monitoring.

The evaluation of structure and process indicators has been based on standards, practice guidelines, and report cards developed through literature reviews, general consensus, and expert panels. A growing number of organizations and agencies have developed or are in the process of developing standards, guidelines, and report cards: JCAHO, NCQA, AHCPR, CHAMPUS, SAIC, CMHS, AMBHA, and NAMI.

Peer review is a second approach used to assess quality of care process, and more specifically, the assessment of appropriateness of care. In a review of the literature, Lee Sechrest noted that peer review of mental health care process is common (Sechrest, 1987). For example, standardized peer review procedures have been used to assess appropriateness of psychiatric hospitalization (Strumwasser et al., 1991) and quality of outpatient services (e.g., Daniels, Kramer, & Mahesh, 1995; Hargrave & Hiatt, 1995). Moreover, researchers affiliated with the RAND Corporation have used a "tracer methodology" involving the clinical review of medical records to assess quality of care (Wells et al., 1993).

Finally, outcomes monitoring has grown in popularity over the past few years as a way to assess quality (Guadagnoli & McNeil, 1994). This method assumes that quality care has been delivered if, for example, clients are found to have decreased symptoms and/or increased functioning after treatment, or clients report they are satisfied with treatment.

Problems with Current Approaches to Monitoring Quality of Care

Three glaring problems are evident with these approaches to assessing quality of care. First, the validity of structure and process indicators remains in question, because the extent to which these indicators are linked to outcome is unknown. The Institute of Medicine's (IOM; 1991) definition of quality care referred to "the degree to which services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge" (p.1). Only those quality indicators for which links among structure, process, and outcome exist can be referred to as valid (AHCPR, 1995; Wells & Brook, 1989).

Unfortunately, structure and process indicators are mostly based on expert judgment, which may reflect what we call aesthetic quality and may not be associated with improved outcomes. Despite their intuitive attractiveness, these indicators may have no functional use. For example, the setting of a program, such as a spacious and pleasant physical environment, might not be tied to a clinical physical environment, might not be tied to a clinical outcome as one might theorize. Credentials and provider experience might be another example of aesthetic quality. Neither of these have been clearly linked to better clinical outcomes (Berman & Norton, 1985; Durlak, 1979; Stein & Lambert, 1984; Weisz, Weiss, Alicke, & Klotz, 1987). Some promising links between service processes and clinical outcome have been found for outpatient psychotherapy. However, most of this work resulted from laboratory research. Little research has been conducted in community-based settings. It is our concern that the lack of valid indicators may result in meaningless quality assurance and continuous quality improvement efforts.

A second problem with the current assessment of quality concerns peer reviews. Peer review approaches to assessing quality have been criticized for being unreliable. For example, studies have found low inter-rater reliability for peer reviews of the quality of outpatient psychotherapy (Cohen & Nelson, 1982; Dall & Clairborn, 1982). Based on his review of the research, Sechrest (1987) concluded that peer review is of limited use for assessing quality. This is due to the fact that peer review is based on intuition and theoretical biases that may result in erroneous conclusions. The unreliability of panel reviews is evident in studies that examine factors impacting the evaluation of appropriateness. Research has shown, for example, that panel composition (Fraser, Pilpel, Kosecoff, & Brook, 1994) and knowledge of clinical outcome before judgments of appropriateness (Caplan, Posner, & Cheney, 1991) have been found to influence peer review ratings of appropriateness.

A third problem with current quality assessment approaches is that outcome monitoring alone does not provide any information about the quality of care that supposedly led to those outcomes. Interpreting outcomes should be done with great caution, because outcomes may have occurred as a result of many influences other than the services provided. Threats to internal validity may include history and maturation, involvement in nonprofessional programs, or natural recovery processes. Whereas Donabedian (1980) recognized the need to examine outcomes that can be attributed to antecedent health care, mental health services researchers often do not attempt to distinguish between services-related outcomes and non-services-related changes.

Quality as Relationship Between Structure, Process, and Outcome

In order to refocus our attention on the meaningful assessment of quality, effort needs to be made to study the validity of quality indicators. In order to further this research, we propose a model whereby quality is viewed strictly as the relationship between quality indicators (i.e., structure and process variables) and quality validators (i.e., outcomes: see Figure 1). This is in contrast to viewing quality as existing separately within each component. Given quality as existing separately within each component. Given this conceptualization, the quality of a specific structure or process variable is determined by the extent to which it is related to some outcome. Given this understanding of quality, quality of care research would examine the links between quality indicators and validators. For example, coordination of services, a structural variable, may be found to be significantly associated with decreased symptoms and increased functioning. Coordination of services would then be viewed as a valid quality indicator of decreased symptoms and increased functioning. Interpersonal process between the clinician and child/family may be found to be significantly associated with satisfaction, but not the other outcome domains. Therefore, interpersonal process would be viewed as a quality indicator of satisfaction. Completeness of paperwork, another process indicator, may be found to be unrelated to any indicator of outcome and would therefore not be considered a valid quality indicator of clinical outcome.

Advantages of Adopting this Conceptualization of Quality

Adoption of this conceptual framework of quality will benefit the field in a number of ways. First, and most important, measuring valid quality indicators and making changes in response to this data (e.g., through continuous quality improvement efforts) will mean better services for children and families. Second, rather than making broad statements about the quality of a particular service or program, providers and evaluators will be able to explicitly state what outcomes are associated with specific structural or process features. For example, a particular service or program will be able to say that they have short waiting periods that have been shown to be associated with high satisfaction, offer services according to practice guidelines that have been found to be associated with better clinical outcomes, and follow established procedures to protect client rights to confidentiality. Third, distinguishing between outcomes associated with the various indicators will assist policymakers and administrators in making more informed decisions about the utility of certain program features over others. For example, improvement efforts aimed at altering process indicators associated with decreased symptoms and increased functioning might be encouraged over those indicators associated with higher satisfaction.

In conclusion, current quality assurance and continuous quality improvement efforts are limited in their impact to the extent that the quality indicators used are valid. The validity of quality indicators is crucial if we are to meaningfully examine quality of care.

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Symposium:

Utilization of the Child and Adolescent Functional Assessment Scale (CAFAS) for Assessing Program and Clinical Outcomes

Authors

Introduction

CAFAS: Evaluating Statewide Service, Method, Results,Discussion, References

The Utilization of the CAFAS for Assessing Program and Clinical Outcomes, Mental Health Policy, and Child Outcomes, Method, Preliminary Findings, Discussion, References

Introduction

The Child and Adolescent Functional Assessment Scale (CAFAS; Hodges, 1990) provides information on impairment which can be used to shape the course of clinical care and policy decision-making. It provides for child's overall functioning score as well as scale scores for eight psychosocial areas (i.e., school/work, home, community relationships, moods, self-harmful behavior, substance use, and abnormal thinking). The CAFAS is currently being used to describe the service needs of youth in care and to assess outcomes. In Tennessee, an innovative program sponsored by the Tennessee Commission on Children and Youth uses the CAFAS to asses a sample of all youth in the state's custody, served by protective services, mental health, juvenile justice, or educational programs. The first stage of an outcome study being conducted on youth served by the Department of Mental Health in Missouri is also presented.

CAFAS: Evaluating Statewide Service

Craig Anne Heflinger & Celeste G. Simpkins

The Child and Adolescent Functional Assessment Scale (CAFAS: Hodges, 1990) was used to measure psychosocial functioning for children and youth in state care as part of the Children's Plan Outcome Review Team (C-PORT). The C-PORT is conducted by the Tennessee Commission on Children and Youth (TCCY) as an evaluation of the service system for children in custody of the State of Tennessee.

The C-PORT was initiated in 1994. This report summarizes the findings of the 1994 and 1995 data collection efforts of child psycho-social functioning that included 846 children and youth ages 3 to 21 years of age. For the overall C-PORT findings, see TCCY (1996).

Method

Sample

The C-PORT uses a proportional stratified sample design. There is a base population of approximately 12,000 children in custody at any given time being served by any of 14 Assessment and Care Coordination Teams (ACCT). Within each ACCT region, cases are assigned to one of 27 categories based on age (birth - 5, 6 - 12, and 13 or more years), current placement type (family home, foster home, or group placement), and adjudication type (dependent/neglected, unruly, or delinquent). Cases were randomly selected from each of the 27 categories, based on the proportion within the ACCT region population.

The resulting sample for 1994 was 357, and for 1995, it was 674, for a total of 1,031 children and adolescents (see Table 1). The CAFAS was completed for 283 children in 1994 and 563 in 1995. The characteristics of the CAFAS sample for 1994-1995 are shown in Table 1. The majority of these youth were 13 years old or over (68%), white (69%), male (57%), dependent/neglected (61%), and lived in a foster home (38%) or group residence (39%).

Source of Data

Data were collected by C-PORT staff from record reviews as well as interviews with the child, primary caretaker, parent (if different from the primary caretaker), and teacher (if appropriate) from a sample of children in custody of the state of Tennessee.

Measurement Instrument

The CAFAS (Hodges, 1990) is an interviewer-rated instrument used to measure children's functioning across five domains: role performance, thinking, behavior towards self and others, moods and emotions, and substance use.

self and others, moods and emotions, and substance use. Two additional subscales describe the current caregiver's ability to provide for the youth's material needs and for his or her emotional/social needs. The CAFAS has demonstrated good interrater reliability (Hodges & Wong, 1996) and validity (Hodges & Gust, 1995; Hodges & Wong, in press) and is currently being used by numerous states to describe children receiving state funded services and in the Center for Mental Health Services national evaluation of system of care demonstration projects.

The CAFAS was completed at the end of a case review and interview, based on information from the structured interviews and case reviews of the C-PORT protocol. Training on completion of the CAFAS was conducted by staff of the Center for Mental Health Policy at Vanderbilt University. Descriptive statistics were used to develop a profile of the CAFAS sample and functioning levels of the youth as well as to describe the 1994-1995 differences.

Results

Measures of psychosocial functioning attempt to describe the child's ability or inability to function in his or her community in a variety of age-appropriate ways. Although many of the children were rated as functioning in the average range for their age for specific areas, up to half of them demonstrated some type of impairment in each of the different types of functioning measured. Two-thirds (67%) were rated in need of treatment, in contrast to the approximately 80% of children who were given a positive rating of emotional well-being as part of the C-PORT (TCCY, 1996). That rating of emotional well-being, however, does not attempt to address the actual emotional health or problems of this population but rather whether the service system has identified and addressed those emotional needs if they exist. Therefore, these CAFAS ratings provide the needed descriptive information on just how, and how well, these children and youth in state custody are actually functioning on a daily basis.

The two domains in which the children exhibited the most problems in functioning were role performance (i.e., the effectiveness with which the child fulfills the roles most relevant to his or her place in the community) and behavior toward self or others. Two thirds of the children (66%) were rated as impaired in at least one of the five areas, with half receiving impaired ratings in two or more areas. Overall, the CAFAS scores indicated the following treatment needs for the population of children and youth in state care: (a) 33% in need of supportive intervention; (b) 30% in need of short-term treatment (likely on an outpatient basis); (c) 25% in need of more intensive services likely in excess of six months; and (d) 12% in need of intensive services and likely needing some type of services on a longer term basis.

Over half (53%) of the children had a formal mental health diagnosis reported, and of these, many were also rated with moderate or severe impairment in psychosocial functioning.

moderate or severe impairment in psychosocial functioning. Using the twofold definition of the Tennessee Department of Mental Health and Mental Retardation that requires both of these documented problems to be classified as seriously emotionally disturbed (DMHMR Priority 2), 29% of the children could be so classified.

The proportion of children and youth, categorized by custodial department, with moderate or severe impairment indicating need for more intensive or longer term mental health services were: Department of Mental Health and Mental Retardation (83%), Department of Youth Development (58%), Tennessee Preparatory School of the Department of Education (41%), and Department of Human Services (32%).

The relationship between child age and psychosocial functioning was found to be significant with younger children (less than 6 years of age) demonstrating less impairment. In both of the two older age groups, 6 - 12 years and 13 or more years, substantial levels of impairment were reported. Significant differences were also found for gender (i.e., males were reported as having more psychosocial impairments). Race of the children was also examined, but no statistically significant differences were found (see Table 2).

The type of residence in which the child or youth currently was placed was also found to relate significantly to the level of impairment of the children and youth in all areas. Children in group placements scored as significantly more impaired (mean CAFAS 43.1) than children in family (mean 28.5) or foster (mean 20.2) homes. Also related to the child's placement, the child's level of functioning impairment was found to be significantly higher when he or she had experienced a greater number of placements (see Table 3). In other words, the children who had the most instability of placement were those with the greatest problems in their ability to function on a daily basis. The children who had been in their current placement for the shortest amount of time were those with the greatest psychosocial functioning impairment. These were frequently the children who had been in multiple placements so that the placement at the time of the C-PORT interview was shorter than the children who were functioning better and staying longer in their placements.

In addition, the relationships between CAFAS ratings of psychosocial impairment and the C-PORT ratings of child and family status and system performance were examined. The predicted relationships between better (less impaired) functioning and positive emotional well-being, positive educational/vocational progress, and progress achievement was found to be significant. In contrast, children and youth with greater impairment in psychosocial functioning were found to be more likely to receive negative status ratings in emotional well-being or educational/vocational progress or inadequate status in progress achievement.

inadequate status in progress achievement.

The CAFAS also provides a rating of general caregiver functioning. The ability of the current caregiver to provide for the basic needs of the child includes provision of food, shelter, clothing, medical care, and safety. The social resources of a family or the current caregiver are also critical to child development. Almost all (95%) of the current caregivers were rated as providing basic material resources and meeting the physical and safety needs of children in state custody, and 82% were rated as providing necessary emotional and social support to meet the child's developmental needs.

Discussion

Several additional comments are needed regarding the performance of the CAFAS in the C-PORT reviews. First, it is obvious from the above findings that the inclusion of the CAFAS provides much more information about the functioning of the children and youth in state custody than reliance on the single child characteristic of emotional well-being (positive vs. negative status). The CAFAS provides a relatively cost-effective mechanism for allowing in-depth description of the needs of children in state care in the domains of their daily functioning including: (a) role performance at home, in school, and in the community; (b) clear thinking and thought processing; (c) behavior towards self and others; (d) moods and emotions; and (e) substance use. Second, the CAFAS results reported above "make sense," which is important when adding a new data collection method, in that the results correspond to other evidence from family members and caseworkers who have described the problems and needs of these children. Thus, the validity of the CAFAS in this setting is supported.

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The Utilization of the Child and Adolescent Functional Assessment Scale for Assessing Program and Clinical Outcomes, Mental Health Policy, and Child Outcomes in Missouri

La Vonne Daniels & Lisa Clements

Introduction

This summary describes the initial findings of a statewide study to assess outcomes for children and families served by agencies funded by the Missouri Department of Mental Health (DMH). The study, which is part of a broad based study encompassing mental health, substance abuse, and developmental disabilities services, was funded by the state legislature.

The aim of the study is to assess outcomes for a representative sample of children who receive services in four treatment modalities: (a) residential facilities, (b) acute inpatient facilities, (c) outpatient and day treatment programs, and (d) intensive in-home programs. The design is longitudinal and will measure client functioning at two successive points in time, 6 months apart. The study includes both new admissions and a sample of active clients who are at various points in the treatment process. In addition, discharge data will also be gathered for children served in acute care inpatient and intensive in-home services.

Method

Measures include instruments to assess functional and clinical status of the child, as well as measures of family empowerment and family satisfaction. Instruments for the study are the Child and Adolescent Functional Assessment Scale (CAFAS; Hodges, 1990), the parent version of the Child Behavior Checklist (CBCL; Achenbach & Edelbrock, 1991), the Children's Global Assessment Scale (G-GAS; Schaffer et al., 1983), the Family Empowerment Scale (FES; Koren, DeChillo, & Friesen, 1992), and the Family Satisfaction and Needs Questionnaire (Daniels, 1995). In addition, the Admission Checklist for Children and Youth, a DMH form for classifying children as seriously emotionally disturbed or acutely disturbed, and a form for capturing demographic data were also utilized in the study.

The study was implemented October 1, 1995. During the months of October and November, data were collected for all new admissions to the system statewide. Data were also collected for a representative sample of active clients in each of the major treatment settings. Agencies participating in the study include 31 outpatient programs, 4 acute care in the study include 31 outpatient programs, 4 acute care inpatient programs, 11 intensive in-home programs, and 9 residential treatment programs. Prior to the implementation of the study, sessions were held at 3 locations in the state to train agencies' staff on the assessment instruments and to describe procedures for implementation of the study. Protocols, with instructions and all the data collection forms and instruments, were prepared by Missouri Institute of Mental Health (MIMH) and forwarded to local agencies. Protocols for children included in the active client sample were pre-labeled with identifying information for each child.

Preliminary Findings

As of February 1, 1996, data had been received for 458 children, representing all four target groups. Preliminary analyses have been prepared for two groups, children who were active clients in residential care (N = 56) and children who were new admissions for outpatient or day treatment services (N = 159).

Characteristics of Children in Residential Care

Children in residential care for whom responses were received were primarily Caucasian males (52%) between 13 and 15 years of age (48%). The majority were in the custody of parents (57%), while 30% were in the custody of the Department of Social Services. The primary diagnosis for 20% of the group was conduct disorder, with oppositional defiant disorder and attention deficit hyperactivity disorder accounting for an additional 32% of the group.

The children had high levels of multi-agency involvement. Sixty-six percent were involved with Child Protective Services, and 86% were special education students. Only a small proportion (two percent) were reported to be involved with Substance Abuse Agencies.

Characteristics of Children in Outpatient or Day Treatment Care

Children who were admitted for outpatient or day treatment care during the data collection period were primarily Caucasian males (56%). Sixty-six percent were ages 10-18 years of age. The majority were in the custody of parents (86%). Thirty percent had previously been a client of DMH.

The primary diagnosis for 26% of the group was attention deficit hyperactivity disorder, with oppositional defiant disorder accounting for an additional 20% of the group. The children had some multi-agency involvement; 23% were involved with Child Protective Services, and 30% were special education students. Similar to children in residential care, only two percent were reported to be involved with Substance Abuse Agencies. While primary living setting for children three months prior to data collection was with their family (86%), 14% also had psychiatric inpatient care within the same time period.

Discussion

At this point in the study, only descriptive analyses of the data are appropriate. This is especially true since the return rate for the outpatient group is relatively low, and group sizes are very different. However, some differences between the outpatient/day treatment admissions group and the residential active client group can be noted.

Children in residential care were older than children admitted for outpatient/day treatment and were predominantly male. The residential treatment group were much more likely to have been involved with Child Protective Services (66% vs 23%) and much more likely to be receiving special education services (86% vs. 30%). Children in the residential treatment group also had substantially higher levels of multi-agency involvement (75% vs. 30.8%).

Among the residential active client group, 20% of the group had a primary diagnosis of conduct disorder, whereas only 2% of children in the outpatient/day treatment admission group had conduct disorder as a primary diagnosis. In contrast, a primary diagnosis of attention deficit hyperactivity disorder was more likely among the outpatient/day treatment group (26%) than for the residential group (16.1%).

Results of the CAFAS revealed differences between the residential treatment group and the outpatient/day treatment admissions group as well. Although scores for Role Performance indicated that the majority of both groups fell within the severe impairment category, 82% of the residential treatment group compared to 59% of the outpatient/day treatment admissions group scored at the severe level of impairment. The Role Performance subscales scores indicate a substantial proportion of both groups (37.5% for the residential group, 41% for the outpatient/day treatment group) were having severe problems at school or work. However, a far greater proportion of the residential group scored at the severe impairment level on the Home subscale (80%) compared to the outpatient admission group (47%). Although more than fifty percent of the children in both the outpatient and residential groups scored at the "no impairment" level for the Community subscale, the residential group had a greater percentage of children scoring at the severe impairment level for this subscale.

Another notable difference in CAFAS scores for the residential and outpatient groups was on the Substance Use Scale. Children in the outpatient group had a greater proportion of the group scoring at the severe, moderate, and mild impairment levels for the Substance Use scale. No children in the residential group were reported to have severe impairment levels, while 25% of the outpatient group scored at this level. Four percent of the residential group scored at the moderate level of impairment, while 45% of the outpatient group scored at this level. When considered across impairment levels, 70% of the outpatient group scored in the moderate or severe impairment level for Substance Use.

The data presented above are for only two of the four groups in the study. The next step is to analyze data for the acute inpatient care and intensive in-home groups and to analyze data for the Family Empowerment Scale and the Family Satisfaction and Needs Questionnaire. Also, in the immediate future, follow-up will be initiated to assure that a statistically representative sample is achieved. In April and May of 1996, follow-up data will be collected for the entire population in the study.

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The Development of a Scale to Assess the Emotional and Behavioral Strengths of Children

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Introduction Content Validity Item Discrimination
Factor Structure Current Efforts

Introduction

In 1994, Kaleidoscope, one of the preeminent child welfare agencies in the nation, received a grant from the Annie E. Casey Foundation to evaluate its Satellite Family Outreach Program. This program's priority is to provide services to children and families presenting many challenges to their systems of care. The children and parents have often been diagnosed as seriously disabled, disturbed, or incorrigible and are in need of intensive treatment service efforts toward integrating them into their home communities and/or family life. The services Kaleidoscope provides are based on the philosophy of Wraparound Care. The key principles of care are: (a) unconditional care, (b) intensive case management, (c) individual planning, (d) family involvement, (e) flexible funding, and (f) cultural competence.

The Satellite Program uses these principles in serving their children and families. A major component of these principles of care is to identify and build upon behavioral strengths of the children and families. In developing the evaluation plan and choosing appropriate instruments for Satellite, the evaluation team noticed that limited numbers of assessment instruments were available to measure children's emotional and behavioral strengths. Additionally, those instruments that did exist lacked acceptable validity and reliability.

Many of the behavior assessment scales currently used in education and psychology are deficit oriented. While these scales are helpful for identifying children in need, they may not be helpful in developing a child's treatment plan or goals. However, strength-based assessment can be used to identify a child's competencies and therefore be useful in developing his/her treatment plans and goals. Strength-based assessment views children and families as individuals with unique talents, life events, and needs. From an ecological perspective, strength-based assessment evaluates children and families across various life domains (e.g., family, social, school, and psychological).

We began to develop the Behavioral and Emotional Strengths Scale (BESS) to provide professionals with a valid and reliable strength-based assessment instrument. The BESS is a 68-item scale that identifies children's behavioral strengths on five dimensions: (1) self-control, (2) affective development, (3) family involvement, (4) school performance, and (5) self-confidence. The scale is designed for teachers and direct service providers to complete on children with whom they work. Each item is comprised of a statement describing a strength children may demonstrate. The respondent then rates the child on a Likert-type scale in terms of how well the item describes the child (i.e., 0 = Not at All Like the Child to 3 = Very Much Like the Child). Completion time is approximately 10-15 minutes. The item scores are then summed to determine the child's total score. To date, the content validity, item discrimination, and factor structure of the BESS have been established.

Content Validity

The content validity of the BESS was determined in several steps. First, in order to focus on important areas of strength and include items meaningful to practitioners, 250 professionals from mental health and social service agencies nationwide were mailed surveys in which they were asked to list up to 10 behaviors that children and adolescents engage in when they begin to show improvement. The survey respondents listed over 1,200 behaviors. The original list was then reduced to 190 by combining similar items. Next, these 190 items were grouped into 15 categories of behavioral strengths (e.g., self responsibility, school performance, peer relations, views of others). Based on these categories, lists comprised of 7-9 items were constructed for use in further surveys. Using the lists of 7-9 items, a second national mailing was made to an additional 400 mental health and social service staff. These professionals were asked to rank order the 190 statements (each respondent ranked three lists) with regard to how important they were to a child's behavioral strengths. Finally, based on median and quartile scores computed for each item, another 63 items were deleted (i.e., those with high median and high quartile scores). The resulting scale consisted of 127 items that described the behavioral strengths that a child may demonstrate.

Item Discrimination

In the spring of 1995, a study was conducted to establish the ability of the BESS to discriminate between children with and without serious emotional disturbance (SED). As part of this study, teachers and direct service providers were asked to complete the 127-item version of the BESS on children with SED (N = 148) and children without SED (N = 110).

with SED (N = 148) and children without SED (N = 110).

One-way analyses of variance (ANOVAs) and Pearson Chi-Square analyses were conducted on each item. The ANOVAs were significant for each item. The children with SED scored significantly lower on each item than did the children without SED. To perform a chi-square analysis, the response choices on the Likert-scale were collapsed for comparison. The "Not at All Like" choice remained a single category, the other three choices (i.e., "Not Much Like", "Like", and "Very Much Like") were combined into a general "Like" category. A 2 ("Not at All Like" v. "Like") X 2 (SED v. Non-SED) Pearson Chi-Square test was conducted for each item. The analysis identified 37 items on which children with SED and those without SED did not differ. An additional 10 items were eliminated because a sufficient number of cells with the minimum expected frequency for a specific item was not obtained. These items were discarded resulting in an 80 item version of the BESS.

Factor Structure

Having determined the content validity and item discrimination, we conducted factor analyses to determine the important domains of behavioral strengths assessed by the BESS. The factor analyses occurred in two steps. First, using the data set from the 258 children who had scales completed, an oblique factor analysis with item loadings set at .40 was conducted. Nine factors emerged. Second, further factor analyses were conducted with eigenvalues set at 1.5, item loadings set at .40, and four items set as the minimum number of items in any factor. Five meaningful factors comprised of 68 items were identified: (1) Self-Control, (2) Affective Development, (3) Family Involvement, (4) School Performance, and (5) Self-Confidence. See Figure 1 for items in each factor.

Current Efforts

Currently, efforts are being made to establish norms for the Behavioral and Emotional Strengths Scale (BESS). As of May 1996, the scale has been completed on approximately 1800 children with and without SED nationwide. Additionally, a number of studies to determine the validity and reliability of the BESS have been completed. Three validation studies have been completed. For each study, teachers or direct service providers completed the BESS and either (a) the Teacher Report Form (N = 84), (b) the Harter Self-Perceptions Profile for Children (N = 78), or (c) the Walker- McConnell Scale of Social Competence and School Adjustment (N = 71) on up to 10 of their students. Studies to establish the interrater and test-retest reliability have also been conducted. In these studies, teachers and direct service providers completed the BESS for up to 10 students common to both respondents and at two different intervals. Preliminary analyses are currently underway.

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Development of the Adolescent Treatment Outcomes Module (ATOM)

Authors

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Introduction

As mental health treatment programs come under closer scrutiny by payers who have a range of options for therapeutic services, well-designed evaluations of the clinical utility, acceptability, and societal value of services are needed (Pfeiffer & Strzelecki, 1990). This paper describes development of a module to monitor the outcomes of treatment of adolescents with emotional or behavioral problems.

Although an estimated $5 billion is spent each year in providing mental health services to children and adolescents (Burns, Taube, & Taube, 1990; Rice, Kelman, Miller, & Dunmeyer, 1990), there is virtually no evidence that routine mental health care for youth is effective. While some isolated studies offer optimistic conclusions about the benefits of some forms of treatment (Cause et al., 1994; Clark et al., 1994; Henggeler, Melton, & Smith, 1992; Scherer, Brondino, Henggeler, Melton, & Hanley, 1994), other evaluations suggest that intensive treatment programs show minimal benefits compared to standard care (Bickman et al., 1995; Heneghan, Horwitz, & Leventhal, 1995). Most treatment programs which are considered promising have yet to be evaluated, partly because no comprehensive, standardized set of instruments have been developed for adolescents that are brief, easily administered, and inexpensive. To that end, the Adolescent Treatment Outcomes Module (ATOM) has been constructed. The objective of the ATOM is to (a) provide reliable and valid information about outcomes of care, (b) be applicable across severity levels, clinical settings, interventions, and population groups, and (c) be brief and inexpensive to administer.

Outcomes modules are sets of standardized, validated instruments designed to facilitate the routine and systematic gathering of data on patient response to treatment (Smith, Rost, Fischer, Burnam, & Burns, in press). The ATOM is the sixth in a series of outcomes modules developed by the NIMH Center for Rural Mental Health Services Research, University of Arkansas for Medical Sciences. Steps in the development of the module, components of the module, and preliminary data on a small sample are presented.

Steps in Module Development

Module development began with an extensive review of diagnostic, prognostic, health service, and methodologic issues of adolescent treatment outcome (Robbins & Taylor, 1995). A multi-disciplinary panel of experts was convened to advise the development team on critical components of the module. Experts were recruited from child psychiatric epidemiology, functional measurement in children and adolescents, child mental health services research, structured psychiatric diagnostic instruments for children, and child psychotherapy research. Based on panel recommendations, a draft of the module was composed and presented to panel members for evaluation. Recommended changes were made, and a pilot study to gather validating data has been undertaken.

Module Components

The module is composed of seven domains: (a) focal problems; (b) diagnostic assessment to establish caseness in five diagnostic categories (i.e., anxiety, depression, oppositional defiant disorder, conduct disorder, ADD); (c) multidimensional assessment of functional impairment; (d) family burden; (e) acceptability of treatment; (f) prognostic or risk-adjustment factors that may influence treatment outcome; and (g) assessment of the amount and quality of treatment received. These domains, listed in Table 1, have been identified as most central to understanding outcomes of treatment for emotional and behavioral problems (Hoagwood, Jensen, Petti, & Burns, 1996).

Focal Problems

Youth are referred to clinics not because of a particular diagnosis, but because parents, teachers, or others are concerned about specific problems they are having at home, school, or elsewhere (Weisz & Weiss, 1989). The module identifies the primary reasons for initiating treatment, the seriousness of these problems, and tracks change in presenting problems following treatment.

Caseness and Symptom Severity

It is not feasible within the scope of the module to gather sufficient data to make diagnoses of disorders using full DSM-IV criteria. Therefore, results of item analyses on four large data sets were used to generate a much reduced set of symptoms that are used to identify likely cases of generalized anxiety, separation anxiety, major depression, generalized anxiety, separation anxiety, major depression, oppositional defiant disorder, conduct disorder, and attention deficit hyperactivity. These symptom items have been supplemented with representative symptoms of each disorder, selected on the basis of prevalence, to produce a measure of symptom severity.

Functional Impairment

Therapeutic outcomes in adolescent mental health include both resolution of symptoms and enhanced functioning. Items designed to address domains of functioning were drawn from multiple sources including the Brief Impairment Scale designed by Hector Bird (Bird, 1995) from the tradition of the Columbia Impairment Scale (CIS: Bird, Shaffer, Fisher, Gould, & Staghezza, 1993), and the Child Health Questionnaire (CHQ: Kurtin, Landgraf, & Abetz, 1994). The ATOM also monitors sentinel indicators, relatively rare negative events caused directly or indirectly by emotional or behavioral problems. Sentinel indicators, adapted from draft items of the UNOCCAP study, include inability to remain in the home, expulsion or suspension from school, and frequent arrests. The following domains of functioning are assessed:

- ***Functioning in the family.*** In-home placement is the goal of many residential, therapeutic foster care and family preservation programs and is the primary outcome measure of many evaluations (Gabel & Shindledecker, 1992). Ability of the adolescent to remain in the home, relationships with family members, responsibility at home, and ability to follow home safety rules are measured.
- ***Functioning in school.*** School-related outcomes include acceptance of teacher authority, academic progress, and completion of seatwork. Parental involvement through frequent calls to come to school for behavioral conferences or to pick up an unruly child is also included, as are sentinel indicators of expulsion and suspension.
- ***Community functioning.*** Successful functioning in the community is measured on a sentinel level by ability to comply with societal laws. Number of contacts with the criminal justice system, arrests, time till arrest, incarceration, and residential placement are determined. Additionally, measures of involvement in community activities and use of leisure time are included.
- ***Functioning with friends.*** Peer quality is assessed by determining the ability of the teen to make friends who do not normally break rules and laws and are not regularly in trouble with authority figures. Peer relations are addressed by asking both parent and the adolescent whether (s)he is able to make friends and get along with the friends (s)he has made.

Family Burden

Burden of the family in dealing with the psychopathology of an adolescent is measured by the Burden Assessment Scale developed by Reinhard and colleagues (Reinhard, Gubman, Horwitz, & Minsky, 1994).

Satisfaction with Care

Satisfaction with mental health care services is measured by the Client Satisfaction Questionnaire (CSQ) modified by DeChillo for children (Larsen, Attkisson, Hargreaves, & Tuan, 1979). The CSQ is a brief well-validated instrument for use with parents.

Prognostic or Risk-adjustment Factors

Factors associated with successful outcomes of care were identified from the literature and from consultation with the expert panel. These factors vary across treatment contexts and must be adjusted for in studies comparing outcomes across treatment sites. Items include age of onset of symptoms, age of onset of aggression, psychiatric and substance use comorbidity, mental illness and substance abuse history of parents, parental use of mental health services, recent family stressors, housing instability, and socioeconomic position of the family. Family functioning, shown to be a strong determinant of treatment success, is measured by the general functioning subscale of the McMaster Family Assessment Device (FAD: Byles, Byrne, Boyle, & Offord, 1988).

Treatment Amount and Quality

There is a growing consensus that mental health treatment of adolescents requires multi-modal approaches (Baer & Nietzel, 1991). This view is partly based on disappointing results from clinical studies of the efficacy of single agents. Experience throughout the country with integrated systems of care suggests that a combined therapeutic program is necessary. Assessment of quality and amount of treatment is based on reports of the parent and a chart review guided by a checklist of treatment options. Treatment options include: (a) medications; (b) parent training; (c) crises services; (d) in-home services; (e) individual, family, and group therapy; (f) case-management, and (g) school-based treatments. Frequency of each intervention is documented. Services utilization materials from the National Adolescent and Child Treatment Study conducted by the Research and Training Center for Children's Mental Health (Silver et al., 1992), and the Services Use in Children and Adolescents (Parent Self-Report) instrument developed by the task force on outcomes research of the American Academy of Child and Adolescent Psychiatry were adapted.

Pilot Test of the ATOM

Adolescents, age 11 to 18, from both the inpatient and outpatient units at Arkansas Children's Hospital and the outpatient units at Arkansas Children's Hospital and the Centers for Youth and Families in Little Rock were recruited. Each subject and his/her parent or guardian completed the self-report Baseline Assessment of the ATOM. The adolescent and parent completed the Diagnostic Interview Schedule for Children (DISC: Version 3.0; Shaffer, Schwab-Stone, Fisher, Cohen, Paicenti, Daves, et al., 1993), the Child Behavior Checklist (CBCL: Achenbach, 1991) and the Columbia Impairment Scale (Bird et al., 1993) to allow us to examine the relationships between brief module measures and extensive research measures of overlapping constructs. The admitting clinician completed the Clinician Baseline Assessment.

Of the 37 adolescents referred to the research assistant, 31 (84%) agreed to participate in the study. Complete baseline data have been collected for all enrolled cases. Subjects were 13.8 years old (sd = 1.7) on average, 36% female, and 39% minority, predominantly African American. Common DISC diagnoses include conduct disorder (23%), depression or dysthymia (30%) and attention deficit hyperactivity disorder (26%). All major outcome measures in the module (symptom severity, functioning in the home, functioning in the school, functioning in the community, functioning with peers) show a distribution approaching normal with no evidence of a ceiling or floor effect. We are currently in the process of examining correlations between module and gold standard measures of comparable constructs, while examining patterns in the variation between adolescent and parent reports on outcomes. Sentinel indicators show that 65% of subjects have been suspended from school for one day or more; 40% have had contact with the police in the past six months; and 15% have made many friends who are often in trouble with the authorities. Close to one-fifth of parents (17%) reported missing days at work because of their child's problems, and 44% found the household routine was upset because of the adolescent's problems.

On average, the baseline portion of the module, exclusive of validating instruments, was completed in 25 minutes (sd = 8.6) by adolescents, 28 minutes (sd = 7.8) by parents, and 7 minutes (sd = 9.4) by clinicians. All participants filled out the module with a minimum of missing data: (a) < 2% from adolescents, (b) < 1% from parents, and (c) < 5% from clinicians. Research interviewers began six month follow-up evaluations with patients and parents in July, 1996.

Conclusions

Routine outcomes monitoring requires instruments that are comprehensive, psychometrically sound, and acceptable to patients, families, and agencies. They must therefore be brief, inexpensive, and administered by non-clinicians with only minimal training. To our knowledge, the prototype ATOM is the only currently available battery of instruments that measures all important outcome domains easily and economically. As such, it holds great promise in advancing routine scientifically rigorous outcomes monitoring in

routine scientifically rigorous outcomes monitoring in adolescent mental health care.

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The Development of a Standardized Assessment Protocol in a Community Mental Health Treatment Program

Authors

Introduction Method Results Discussion References

Introduction

Although there are many research studies evaluating the efficacy of various mental health interventions for children and families, there are very few reports of ongoing standardized evaluation of treatment outcomes in community mental health services (Weisz & Weiss, 1989; Weisz, Weiss, & Donenberg, 1992). It is becoming increasingly important that outcome assessment be both widely applied and linked to data on patient characteristics and service utilization (Sederer, Hermann, & Dickey, 1995). Community mental health services are experiencing increased internal and external pressure to document the efficacy of their interventions and the effectiveness of the service system. These pressures have intensified in this era of managed care and diminished resources for mental health services. Furthermore, these pressures dictate that procedures be utilized which are both time and cost efficient (Kurkland, 1995). Unfortunately, increased pressure to evaluate outcomes has not necessarily coincided with the development of well established guidelines for implementing outcomes evaluation. Service settings are left with the difficult task of designing their own protocols, with or without consultation from researchers who have the necessary expertise in measurement and analysis.

The purpose of this study was to describe the process of instituting a standardized mental health assessment protocol in a community mental health treatment program serving maltreated youth. The protocol was specifically not implemented as a research project, but rather as a low cost component of standard clinical practice at the clinic. The goals of this assessment program were to:

- Provide descriptive data regarding the population utilizing the service, and describe individual and group differences in this population
- Examine the efficacy of therapeutic interventions and

provide a mechanism for monitoring quality assurance
- Supply individual clinical data to mental health providers for use in treatment planning and monitoring.

Method

Service Site and Sample

Children's Hospital Center for Child Protection (CCP) Mental Health Treatment Program

The CCP mental health treatment program is an outpatient therapy program specifically for children and adolescents who have experienced maltreatment in the form of sexual, physical, or emotional abuse, or neglect. The majority of patients are referred for sexual abuse. Individual, group, and family treatment are available from an interdisciplinary team of psychologists, social workers, counselors, and trainees. In the fiscal year 1994, the program served more than 250 children and their parents. A standardized assessment protocol was introduced in mid 1994 and data for 242 subjects have been collected.

Description of Sample

Sixty-two percent of the subjects are female; the mean age was 8.7 years (SD = 4.0; range = 2-19). Approximately half of the sample was Caucasian (47%); African Americans and Hispanics composed 20% each of the sample, with the remainder classified as "Other." The majority of the families (61%) had total gross incomes of less than $20,000. Approximately two thirds of the children were referred primarily because of sexual abuse. Six-month follow-up data has been more difficult to obtain, but is currently available for 59 families.

Measures

Table 1, below, presents the measures selected for the assessment program, by domain of assessment and informant.

Issues which were addressed in the selection of instruments included:

- Goals and objectives of intervention (i.e. relevance of measure)
- Psychometric properties of instruments for the population being served (e.g., SES, race/ethnicity, culture, age, etc.), and
- Pragmatic issues, such as time of administration, costs, personnel, and training required.

Procedure

Assessment measures were administered by graduate

Assessment measures were administered by graduate students and research assistants who received training in the administration of the standardized instruments and some limited clinical interviewing skills. Families were scheduled for an intake assessment prior to initiating treatment. Data regarding the assessment were used to assign families to specific types of treatment and providers. A summary of the assessment data was provided to the clinician prior to the family's first visit. Follow-up interviews were scheduled six months after the intake assessment and the same battery of instruments was repeated.

Results

Results are presented and discussed based on the relative success of achieving the program goals and the obstacles confronted within the process.

Goal #1: Provide descriptive data regarding the population utilizing the services.

A great deal of descriptive data has been collected on the 242 youth assessed upon entering the mental health treatment program. Such data includes demographics, maltreatment history, mental health service use history, treatment expectancies, and standardized data regarding mental health and family problems and competencies.

There are, however, limitations in the usefulness of these data; variability in the clinical staff's comfort and familiarity with the instruments jeopardizes the reliability of results. Also, the data may not be representative of all youth and their families utilizing the service due to the difficulty involved in successfully assessing all children and their parents prior to treatment (Boren et al., 1996). Only approximately 60% of those who began treatment were assessed. Anecdotal data suggests that the reasons for missing the intake assessment include, crisis intervention implemented prior to assessment, scheduling difficulties, and language differences.

Goal #2: Examine the efficacy of the therapeutic interventions and provide a mechanism for quality assurance

The utility of the assessment program for evaluating outcomes obviously relies on the ability to collect follow-up data, as well as on the representative coverage of the assessments, as discussed above. To date, follow-up data have been collected for only 59 youth and their families, too few to provide a meaningful assessment of treatment outcomes. Uncertainty regarding whether a true cross-section of the patients is being considered in outcome evaluation may arise due to a lack of full participation in follow-up interviews. This is largely the result of difficulty in tracking some families after their initial interview.

A number of additional obstacles to obtaining reliable

A number of additional obstacles to obtaining reliable follow-up data are worth addressing. One such obstacle, related to clinicians' variable familiarity with the instruments, is the potential for variable commitment of the treatment program staff to standardized assessment. The requirements, for example, of standardization may run counter to the intentions of many clinical providers to adapt to the diverse, idiosyncratic, and changing needs of consumers, thereby seeming incongruent or even contradictory to the clinical and/or administrative procedures of a mental health treatment program. Indeed, lack of consistent commitment could impact the scheduling of intake interviews and follow-ups, further compromising the universality of outcome data collection.

Due to their integral role in the success of such an assessment protocol, clinicians must be highly involved in a collaborative implementation of it. The researchers introducing the procedure must emphasize their role as consultants, and must transfer administrative functions to the clinic in a timely manner. Training and data analysis can remain the researchers' responsibility; however, it is imperative to involve clinicians early in order to establish it as a standard clinical practice, rather than a research project. This entails getting input from clinical staff regarding research questions and constructs to measure prior to the protocol's implementation.

This assessment program was intentionally implemented as an integral component of ongoing clinical practice, as opposed to a discrete research project. Thus, there was no attempt to implement an experimental research design with random assignment to treatment conditions, etc. While this approach offered clinical advantages, there are limitations in the interpretations of results due to the lack of standardized conditions.

Goal #3: Supply individual clinical data to mental health providers for use in treatment planning and monitoring

Clinicians have reported satisfaction with the assessment summaries, although the treatment program manager reports that the summaries are not frequently used for assignment to treatment. Thus, possible variability in clinical utility is an issue of which to be aware.

Changes in the data reporting methods have been instituted due primarily to reimbursement issues. Reimbursement issues arose because the assessment protocol did not match the categories allowed for reimbursable expenses in many public and privately funded managed care programs. The procedures were therefore changed, and made more costly, so that the requirements for reimbursement could be met. Instead of an assessment summary completed by a paraprofessional, a full psychological evaluation report was produced by a licensed clinical psychologist, and the assessment was billed as psychological testing. This change, in some respects, was contrary to the initial purpose of the in some respects, was contrary to the initial purpose of the protocol, which was to provide a low cost assessment program in the implementation of such a protocol.

Discussion

It is feasible to implement a standardized assessment protocol at relatively low cost in a community mental health treatment program. There are, however, several obstacles that need to be addressed including, lack of full coverage, reimbursement requirements, and tracking of families for follow-up. The introduction of standardized assessment to a treatment program requires the following:

- Early involvement and training of staff;
- Planning for fiscal impact and flexibility in reimbursement plan;
- The selection of feasible measures (e.g., time, cost, and training efficient), the data from which will meet the goals of the intervention;
- Well developed database and client tracking systems;
- Linkage of assessment data to service use data; and
- Timeline of implementation and plans for transition from trial to standard clinical practice.

With these issues addressed, a successful standardized assessment protocol can be implemented with benefits to clinicians, administrators, and researchers alike.

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The Family-Centered Behavior Scales: A Report on the Validation Study

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Introduction

Family-centeredness is often listed among desirable elements of programs for children with special needs and their families. Validated instruments to measure family-centered care, however, have been lacking. The author and Christopher Petr have developed and validated an instrument that measures the family-centeredness of professional behavior. The Family-Centered Behavior Scale (FCBS) and its companion tool, the FCBS&endash;Importance, are completed by the parents or guardians of children with special needs. On the FCBS, parents rate how often a professional with whom they work performs certain family-centered behaviors. On the FCBS-Importance, parents rate the importance of each of these behaviors.

Method

Allen & Petr (1995b) conducted a cross-disciplinary review of literature pertaining to family-centered service delivery. Based on this review, they proposed the following definition: Family-centered service delivery, across disciplines and settings, recognizes the centrality of the family in the lives of individuals. It is guided by fully-informed choices made by the family and focuses on the strengths and capabilities of families.

The authors generated a series of measurement scale items that reflected service delivery issues identified in the literature and the definition above. Focus groups of parents, professionals, and the project's advisory committee reviewed this collection of items. The draft of the resulting measurement instrument was field tested by 21 parents of children with emotional/behavioral disturbances.

The final validation edition of the scale had 32 items evaluating staff members' performance and a matching set of items on which parents/guardians rated the importance of each item. A satisfaction-with-this-staff-member question and several demographic questions were included in the research package, which was printed in both English and Spanish. Half of the surveys asked parents to describe their best staff member, while the other half asked parents to evaluate their worst.

Copies of the validation edition of the scale were sent to about 1700 households that included a child with special needs. The distribution lists for the surveys were collected from organizations that dealt with a variety of special needs (i.e., mental health, developmental disabilities, and chronic health problems). Each household was sent two surveys in an attempt to increase the response rate of male caregivers.

Survey Participants

A total of 443 parents/caregivers of 406 different children with special needs returned surveys with enough data to be included in the analysis. About 87% (N = 379) were female; the average age was 41 years. Nearly 85% (N = 376) were biological parents of the child with special needs. Most of the parents were White (73%, N = 323), 16% (N = 71) were African- American, and 7% (N = 32) were Hispanic/Latino. Of the parents/caregivers, 71% (N = 313) were married, 13% (N = 56) were divorced, and 11% (N = 48) had never married. Annual household income averaged around $35,000. Responses came from 45 different states.

The children who worked with staff members described in the survey were predominantly male (63%, N = 252); their average age was 10.7 years. A total of 68% (N = 275) were White, 17% (N = 68) were African-American, and 7% (N = 29) were Hispanic/Latino. Close to 89% (N = 349) lived with their parents. Respondents rated the severity of disabilities of 19% (N = 74) of the children as mild, 45.5%

disabilities of 19% (N = 74) of the children as mild, 45.5% (N = 177) as moderate, and 35.5% (N = 138) as severe. The most prevalent types of disability were developmental delay (34%, N = 138), mental retardation (32%, N = 128), emotional/behavioral (29%, N = 116), and learning disability (29%, N = 115).

Of the returned surveys, 40% (N = 178) of the respondents described their "best" staff member, 33% (N = 148) described their "worst" staff member, and 15% (N = 65) described their "only" staff member. Most of the professionals were women (75%, N = 323); their average age was 40 years. Most were White (82%, N = 358); 10% (N = 44) were African-American. The most prevalent professions represented were special education teacher (29%, N = 119), social worker (15%, N = 62), and medical doctor (12%, N = 51). The most prevalent settings in which these professionals worked were education (52%, N = 201), health (21%, N = 80), and mental health (11%, N = 42).

Results

Reliability and Validity

Internal consistency of scale items was assessed using Cronbach's alpha coefficient. The standardized alpha for the 32-item scale is .97 (N = 133). The test-retest correlation is .96 (N = 128).

Evidence of scale validity is present in three analyses: the ability of the scale to differentiate between "best" and "worst" staff members, correlations between scale items and satisfaction with the staff member, and importance ratings of respondents. A comparison of means among the best, worst, and only staff members' scores revealed that the means of all 32 items were different at the .0014 level or higher (range: F = 6.7199, 2,367, p = .0014 to F = 191.62, 2,382, p < .0000). Differences were in the expected direction of poorer family-centered performance by "worst" staff members than by "best" staff members.

The researchers hypothesized that families who receive more family-centered care would be more satisfied with staff members that work with them. Zero-order correlations between items on the 32-item scale and satisfaction ranged from .31 to .81. All but four of the correlations were above .52. All correlations were significant at the .000 level, supporting the hypothesis.

Respondents rated all 32 behavior items as important; item means ranged from 3.2 to 4.7 (3 = important, 5 = extremely important). The three most highly-rated importance items pertained to the staff member listening to the family, treating the family with respect, and accepting the family as important team members.

Performance of Family-Centered Behaviors

On a scale of 1 (Never) to 5 (Always), the frequency with which staff member performed the 32 family-centered behaviors ranged from an average of 2.5 to 4.5. For the sample as a whole, the three most frequently performed behaviors were:

- the staff member does not make negative judgments about us because of ways that we are different from the staff member;
- the staff member does not blame me for my child's problems; and
- the staff member does not criticize what we do with our child.

The three least-often performed behaviors were:

- when we want to meet other families that have children like ours, the staff member helps us meet them;
- the staff member helps my family get services from other agencies or programs as easily as possible; and
- the staff member helps us get the help we want from our family, friends, and community.

Scale Revision

The researchers wanted to reduce the size of the scale to make it more user-friendly. Six items were eliminated from the scale, two because they performed badly in several analyses and four because they elicited a relatively large number of missing responses and did not seem to make unique contributions to the scale. The alpha coefficient for the resulting 26-item Family-Centered Behavior Scale (N = 206) is .98.

Differences for Families with Children who have Emotional/Behavioral Disabilities

One-way ANOVA tests were used on the final 26 scale items to explore differences between scores given by the subpopulation of caregivers whose children had emotional/behavioral problems (EBD) and by those whose children did not have emotional/behavioral problems (non-EBD). The EBD subsample rated five behaviors significantly higher in importance than the non-EBD subsample. These items were:

- the staff member helps my family get services from other agencies or programs as easily as possible ($F = 15.70, 1,433, p = .0001$);
- the staff member helps us get the help we want from our family, friends, and community ($F = 14.67, 1,431, p = .0001$);
- the staff member helps us get all the information we want and/or need ($F = 7.67, 1,435, p < .01$);
- the staff member cares about our entire family (F =

6.74, 1,433, p < .01); and

- the staff member accepts our family as important members of the team that helps our child (F = 5.92, 1, 436, p < .05).

The groups had similar ratings on the behaviors performed most frequently. The overall scale mean for the EBD subsample (3.23), however, was significantly lower than the non-EBD subsample (3.76; F = 26.14, 1,439, p < .0001). The EBD subsample rated every behavior as being performed less frequently than the non-EBD subsample (range: F = 5.80, 1,389, p < .05 to F = 34.00, 1,396, p = .0000).

The researchers also examined the level of agreement between the importance ratings and the frequency ratings. Difference scores were computed for each item by subtracting the importance score from the frequency score. Difference scores close to zero indicate a good match between consumers' ratings of importance of a behavior and the frequency with which it is practiced. Positive scores signify that frequency exceeds importance, while negative score signify that frequency is below importance. Difference scores for the EBD subsample were significantly lower (less family-centered) than the non-EBD subsample on every behavior (range: F = 6.14, 1,380, p ² .05 to F = 33.32, 1,420, p = .0000).

Discussion

The Family-Centered Behavior Scale can be used to inform service delivery systems of professional behaviors deemed important by caregivers of children with special needs. Organizations or systems that deliver services to children with special needs and their families may use the FCBS as part of their assessment of the extent to which they provide services in a family-centered manner. It may be used to inform a program of its particular strengths and weaknesses in terms of family-centeredness. Plans for ways to improve on the areas identified as weak can be developed and carried out, and the scale then be administered again to assess the impact of intervention on service delivery. The FCBS also may be used to study the relationship between family-centered service delivery and outcomes that are important to families and organizations. Results of studies using the scale may be helpful to professional training programs that wish to educate providers about family-centered service approaches.

Results of this study suggest that professional training and system reform efforts may be especially important for children with emotional/behavioral disturbances and their families. Caregivers of children with emotional and behavioral problems in this sample experience their professional interactions as less family-centered than do parents of children with other disabilities. Family-centered behaviors were performed less frequently with the EBD subsample. In addition, the discrepancy between importance ratings and frequency was greater, compounding the negative effects.

The FCBS may be purchased as part of the Family-Centered Behavior Scale and User's Manual (Allen, Petr, & Brown, 1995a) from the Beach Center on Families and Disability, The University of Kansas, 3111 Haworth Hall, Lawrence, KS 66045.

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A Brief Multi-Dimensional Children's Level-of-Functioning Tool

Authors

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Introduction

Child psychiatric epidemiology is a rapidly developing field (e.g., Brandenburg, Friedman, & Silver, 1990; Costello, 1989; Koot & Verhulst, 1992), and with it, the need for adequate assessment tools has become apparent. Mental health concerns in children can be assessed in a variety of ways including: (a) psychiatric diagnosis using the DSM-IV; (b) level-of-functioning (LOF); (c) diagnosis plus LOF; and (d) exposure to risk factors for mental illness. Most commonly, diagnosis plus indication of LOF is used (Costello, Burns, Angold, & Leaf, 1993). However, there is a lack of adequate LOF instrumentation for youth.

One instrument often used to measure LOF is the Children's Global Assessment Scale (CGAS; Schaffer et al., 1983). This single-item 0 - 100 scale was designed to be parallel in structure to the Global Assessment of Functioning scale for adults (GAF; Endicott, Spitzer, Fleiss, & Cohen, 1976) which is rated as axis V of a DSM diagnosis. Both the CGAS and GAF are intended to be rated by trained clinicians. A weakness of uni-dimensional scales is that they provide little information about the nature and complexity of children's mental health problems. Some youth may have rather prominent emotional/behavior problems in one setting (e.g., home/family, school) but not others. A single rating does not capture such subtleties. Similarly, certain domains are not recognized at all by such a scale (e.g., legal, health). Further, only multi-dimensional scales provide adequate information on which to describe clinically similar groups of youth that can provide the basis for designing services and service packages (e.g., Smukler, Sherman, Srebnik, & Uehara, in press).

The Child and Adolescent Functioning Assessment Scale (CAFAS; Hodges, Bickman, & Kurtz, 1991) addresses some of the weaknesses of uni-dimensional LOF scales. The measure assesses five domains of child functioning: role performance, thinking, behavior, moods/emotions, and substance use. Caregiver resources are also rated. Each domain is rated on a 4-point severity scale with behavioral anchors for each rating. This scale is appealing due to its rich behavioral descriptions for each functioning domain, and it has been used in large-scale mental health services projects (e.g., Fort Bragg). However, extensive training of interviewers is needed to obtain adequate inter-rater reliability. Furthermore, the interview itself, on which ratings are based, is lengthy.

Given the limitations of available LOF instruments for children and adolescents, development of a brief multi-dimensional LOF instrument, that requires little or no training to be rated by clinicians as well as parents, would be a valuable contribution to the field. This paper presents data describing the development and preliminary data on such an instrument, the "Ecology Rating Scale."

Methods

Participants

The study collected data from 74 parents of children (age 4-18), who were current clients at one of six community mental health centers in two large geographic regions of Washington state. The regions encompassed rural, suburban and small urban centers. Regions were selected as part of a larger systems' evaluation assessing the impact of replacing mental health process regulations with clinical outcomes as a method of accountability.

The sample was 71% male and 13% ethnic minority. Ninety-three percent were Medicaid-eligible. Diagnoses were primarily adjustment disorder (43%), attention deficit (23%), oppositional defiant disorder (10%), and depression/dysthymia (10%). The sample was representative of the total served child populations of the selected regions in terms of gender, age, diagnostic mix, and income type. Participants who completed baseline surveys were contacted to complete assessment materials again six months later.

Case managers of participating child clients were also asked to complete a brief assessment of client functioning and symptoms. Of the 74 participating child clients, 41 case manager assessments were completed.

Instruments

Ecology Rating Scale. The Ecology Rating Scale (ERS) was designed by quality assurance and children's mental health service staff at a community mental health center with input from families of child clients. The ERS is a brief, multi-dimensional level-of-functioning instrument that can be rated by parents or clinicians. The ERS is comprised of seven domains of youth functioning: family, school, emotional, legal/justice, recreational, health, and social (see Figure 1). For each domain, respondents are asked to "assess the degree to which the child's life is influenced," in "assess the degree to which the child's life is influenced," in the particular domain, by problems associated with his/her emotional/behavioral difficulties. Each domain is rated on a 5-point scale of severity from no problems to severe problems that represents that degree to which the domain is influenced by the child's emotional/behavioral problems. Behavioral anchors are written on the scale itself for moderate (3) and severe (5) levels.

Conner's Parent Rating Scale. The Conner's Parent Rating Scale (Conners, 1970), is comprised of 48 children's symptoms and behavior problems, each rated on a 4-point severity scale. The instrument is appropriate for use with children age 3 to 17 and when age-by-gender norms are available. The instrument yields five factors: conduct problems, learning problems, psychosomatic symptoms, impulsive-hyperactive symptoms, and anxiety symptoms. Adequate reliability and validity have been demonstrated with this instrument (Conners, 1985).

Children's Global Assessment Scale. For participating child clients, case managers completed a brief functioning and symptom assessment that included the Ecology Rating Scale and the Children's Global Assessment Scale (CGAS; Shaffer et al, 1983) described above. Studies have demonstrated adequate inter-rater reliability as well as concurrent and discriminant validity for the CGAS (Bird, Canino, Rubio-Stipec, & Ribera, 1987; Shaffer, et al., 1983; Steinhausen, 1987).

Information Systems Data. Data gathered from participating agency's information systems provided information on client's socio-demographic characteristics, residential situation, work/school involvement, and service utilization.

Results

The first step in analysis of the adequacy of the ERS was to examine the distribution of scale scores. Scale scores were normally distributed with the exception of scores for legal and health scales, domains for which few children demonstrated difficulties. Reliability and validity were then examined and findings are described below.

Reliability

The reliability of the ERS was examined with respect to both internal consistency and inter-rater reliability. While the ERS is composed of seven domains, each believed to contribute unique information, we did not expect domain ratings to be completely orthogonal. Rather, we expected moderate to high internal consistency for the scale as a whole. Results supported this expectation with alpha coefficients of .70 for parent ratings (N = 65) and .69 for clinician ratings (N = 41).

Inter-rater reliability was tested with ERS scores from 27

Inter-rater reliability was tested with ERS scores from 27 clients rated by two clinicians who reportedly knew the clients well. Results suggested that reliability was potentially adequate for family, legal, recreation, and social domains, with intra-class correlations of .50, .65, .71., and .83 respectively. Intra-class correlations for the remaining scales were less than adequate and are as follows: school (.44), emotions (.37), and health domains (.38). If used as an overall index of functioning, however, the total ERS score demonstrated strong inter-rater reliability with an intra-class correlation of .75.

Validity

Concurrent validity was first examined as the correlation between clinician-rated ERS scores and the CGAS (N = 41). Although school and emotion domains demonstrated relatively weak inter-rater reliability, they were among the scales with stronger concurrent validity with the CGAS, with correlations of .62 and .54., respectively, both significant at the $p < .001$ level. The recreation ($r = .49$) and social scales ($r = .45$) were significantly correlated to the CGAS at the $p < .01$ level. Family, legal, and health domains were moderately, though non-significantly, correlated with the CGAS with correlations ranging from $r = .27$ to .41. The total ERS score was strongly and significantly correlated with the CGAS ($r = .72$, $p < .001$).

Correlations between parent-rated ERS scores and subscale scores of the Conner's Parent Rating Scale were conducted as a second means of obtaining concurrent validity information. Predicted relationships are shown in Table 1.

Consistent with expectations, parents' perceptions of problems in the "family" and "emotions" domains were associated with externalizing behaviors such as the "impulsive-hyperactivity" and "conduct" subscales. Also, as predicted, problems in the "school" domain were associated with learning problems. Health problems were related to anxiety, consistent with expectations regarding the relationship of somatization with anxiety. Social and recreation problems were associated with conduct difficulties. This relationship is reasonable considering that youth with conduct issues will likely have difficulty getting along with others socially and in recreational settings (as well as within the family). Legal problems were also predicted to be associated with the conduct subscale; and the lack of association could be due to restriction of range on the legal domain scale. The ERS total score, as rated by parents, appears to be most highly related to externalizing behavior problems and learning problems, rather than internalizing problems.

Treatment validity was tested through examination of whether ERS scores change over the course of six months of outpatient mental health treatment. The numbers of individuals who demonstrated change, and whether the sample change was significant, according to t-test sample change was significant, according to t-test comparisons for matched samples is shown in Tables 2 and 3.

Table 2 shows parent ERS ratings, and Table 3 shows case manager ERS ratings. The number of individuals showing improvement relative to those demonstrating no change or declining functioning according to parents is greatest for the following domains: school, emotion, and legal. Case managers also reported many more individuals improving regarding the recreation domain. Overall sample change on the parent-rated ERS scales was significant, and in the expected direction, for two domains. Trends in the expected direction were found for the other ERS scales. Significant change was found on all but the "social" domain for case manager-rated ERS scales.

Discussion

This presentation described a brief, multi-dimensional, LOF instrument for youth, the Ecology Rating Scale (ERS). The ERS assesses functioning across 7 life domains: school, emotions, legal, health, recreation, social, and family. In contrast to extant measures, the ERS has the following unique combination of attributes: (a) assesses multiple domains of functioning, (b) requires little training, and (c) demonstrates promising psychometric properties. While we do not advocate use of any LOF tool without proper training, the psychometric characteristics of the ERS reported here were found without clinicians having any training. Ideally, clinicians using such instruments would periodically conduct formal or informal tests of inter-rater agreement in the course of discussing cases among clinical team members.

Study findings regarding the ERS suggested some areas of internal consistency. Inter-rater reliability was strongest for social, recreation, and legal subscales. Other scales had weak inter-rater reliability, perhaps due to assessing behaviors related to non-clinical settings (e.g., school) or less recognizable internal states (e.g., emotions and health). Hodges (1991) also found weak inter-rater agreement for scales assessing internal states. On the other hand, more behavioral anchors combined with rater training may improve inter rater agreement of the ERS.

Concurrent validity was demonstrated for ERS parent ratings with the Conner's behavior rating scale. Clinician ratings on ERS scales were also correlated with a uni-dimensional LOF measures, the Children's Global Assessment Scale. With the exception of the "legal" subscale of the ERS, all ERS scales provided some evidence of concurrent validity. Correlations with the legal subscale were likely affected by restriction of variance of responses on the subscale. Evidence of treatment validity (i.e., significant change in expected direction following 6 months of treatment) is also demonstrated for ERS scales.

Further development of the ERS is needed. In addition to developing more behavioral anchors for scale points, norms for the scale should be developed on a larger sample that includes higher rates of ethnic minority youth.

Preliminary testing of the ERS demonstrates that it shows promise as a brief, practical tool for LOF assessment in youth receiving community mental health services. Uses for such a tool include clinical outcome assessment, performance measurement, continuous quality improvement, and services research.

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Utility of the Daily Adjustment Indicators (DAI) for Assessing Juveniles in Community-Based Care

Authors

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Introduction

In 1984, the U.S. Congress expressed a growing concern regarding the mental health status of children and youth with serious emotional and behavioral disorders, and the system responsible for serving these youth. Under the auspices of the National Institutes of Health, Mental Health Branch, the Child and Adolescent Service System Program (CASSP) was established to promote a comprehensive working model of service provision. As originally presented, this "model" was not intended as a static product, but as a set of guidelines and principles in service of a process of research-driven, bottom-up service system improvement.

Historically, children who suffer from the debilitating influences of serious emotional disturbances have not received services outside very restrictive and controlling settings, and very little meaningful data has been collected which promotes informed treatment or public policy judgments or decisions. Most critically, there exists a serious lack of data regarding how to best serve these youth. Research efforts have principally focused on describing these youth in terms of gross demographic variables and service usage.

The descriptive research approach has provided some basic information about these youth; however, it has not provided much useful information regarding the relative contribution of various psychosocial variables in the process of community integration or exclusion. Identifying the pathways leading to community exclusion, based upon unique youth psychosocial variables, could inform both treatment and policy judgments regarding system needs and improvements.

Purpose

These data are part of an evolving project designed to investigate two related questions: (a) What youth and adolescent psychosocial variables are associated with community exclusion? and (b) Are there consistent pathways of exclusion associated with those psychosocial variables or clusters of variables?

Method

Subjects

The investigators obtained a complete set of demographic data on thirty-five adolescents served in two group living programs. The group living programs were designed to fully integrate these adolescents into all aspects of community life, including public education. The adolescents served by these two programs were either returned to the state, from out-of-state restrictive residential treatment centers, or placed in the group living programs to prevent out-of-state placements. These youth were described as uncontrollable, demonstrating disorders of conduct, including aggression, assault, property damage, law violation, inappropriate sexual behavior, with most having more than one prior psychiatric hospitalization.

Measurement/Instrumentation

In an attempt to identify adolescent behaviors associated with functional problems in the two most influential contextual settings in which youth must participate, the following instruments were employed:

- ***Daily Adjustment Indicators*** (DAI; Burchard, 1990). The DAI is a 25 item behavior checklist designed to be completed by adult caretakers on a daily basis. In this present study, monthly aggregates formed the basic unit of DAI analysis. The score for the adolescents during the second month on each behavioral item was used as a concurrent and potentially predictive variable with the Sutter-Eyberg scores described below. The second full month of data was chosen in an attempt to control for variations in behavioral responding due to a new living environment.
- ***Sutter-Eyberg Student Behavior Inventory*** (SESBI; Sutter & Eyberg, 1992). The SESBI is a 36 item behavior checklist that allows the teacher to rate each child's behavior from never to always. This inventory also rates a second dimension by asking: Is this [behavior] a problem for you? Teachers completed this checklist every other month. This measure includes a total problem score and a total intensity of behavior score for each adolescent. In order to maintain temporal consistency with the DAI data collection, each adolescent's primary teacher completed this checklist at the end of the second month of school. Total "problem" and "intensity" scores formed the basic unit of analysis.

scores formed the basic unit of analysis.

- ***Community-Oriented Programs Environment Scale*** (COPES; Moos, 1987). This instrument, designed for community-based treatment programs, includes 100 items and 10 subscales. Youth rate their living environment every month. Again, total scores associated with the second month formed the basic unit of analysis.

Results

Table 1 shows the means and standard deviations as well as the correlations between the demographic variables and the SESBI scores. Of these, only the number of prior hospitalizations was significantly correlated with the SESBI scores.

Table 2 shows the univariate statistics for and correlations between the components of the DAI and the SESBI. Six of the components were significantly correlated with both of the SESBI scores (marked with *). These six were aggregated into a composite score, and the correlations between this composite score and the SESBI are shown near the bottom of Table 2.

Knowing that the number of prior hospitalizations was the only demographic variable correlated with the SESBI scores, and that these scores were also correlated with the DAI Composite score, a series of multiple regression analyses were completed to examine the incremental utility of the DAI composite score, and to explore the possibility of an interaction between the DAI composite score and selected demographic variables (e.g., number of prior hospitalizations, gender, age, and the COPES).

Table 3 shows the results of a hierarchical regression analysis used to examine the incremental utility of the DAI composite score relative to the number of prior hospitalizations, and whether there was an interaction between these two variables as they relate to the Sutter-Eyberg Problems score. As that table shows, the R square of the two-predictor model was significantly larger than of the model including only the number of prior hospitalizations, indicating that the DAI composite score has independent predictive utility. Further, there is a significant interaction of these variables, as shown in Step 3 of the analysis. Figure 1 represents the form of this interaction, by plotting the simple regression line of the DAI composite onto Sutter-Eyberg Problems for three different values of the number of prior hospitalizations, at one standard deviation above the mean of priors, at the mean of priors, and at one standard deviation below the mean of priors. As the figure shows, the DAI composite score is a better predictor of Sutter-Eyberg Problems for clients with higher numbers of prior hospitalizations (the regression slope is not different from 0.0 for the low priors). Parallel analyses for the Sutter-Eyberg intensity showed that while inclusion of the DAI composite scores did increase the fit of the model above, when only the number of prior hospitalizations was included (R squared increased from .10 to .55, $p < .001$), there was no interaction of priors and the DAI for this criterion variable.

Table 4 shows the results of a hierarchical regression analysis used to examine whether there was an interaction between gender and the DAI composite score, as they relate to the Sutter-Eyberg Problem score. As that table shows (Step 3), there is a significant interaction of these variables. Figure 2 represents the form of this interaction, by plotting the simple regression line of the DAI composite score onto Sutter-Eyberg Problems for males and females as the figure shows, the DAI composite score is a better predictor of Sutter-Eyberg Problems for males (the regression slope is not different from 0.0 for females). Parallel analyses for the Sutter-Eyberg Intensity showed that while inclusion of the DAI composite score did increase the fit of the model above that including only the number of prior hospitalizations (R square increased from .03 to .44, $p < .001$), there was no interaction of Priors and the DAI for this criterion variable.

Additional multiple regression analyses revealed that there was no interaction between the DAI composite and age nor the COPES score, for either Sutter-Eyberg Intensity or Problems.

Conclusions

These results demonstrate that while demographic variables have little utility to predict which adolescents will be excluded from community setting (only the number of prior hospitalizations was correlated with the criterion variables), several items from the DAI were useful. A composite of these items (physical aggression, verbal aggression, sexual acting-out, anxious behavior, and police contact) was substantially correlated with both the Sutter-Eyberg Intensity and Problem scores.

Further, with respect to the SESBI score, this DAI Composite showed interactions with both gender and number of prior hospitalizations. The patterns of these interactions raised the possibility that different patterns of behavior may serve as better predictors for females than males, and for those with fewer prior hospitalizations.

Based on these findings, we would like to encourage the further exploration of the utility of the DAI and the SESBI for studying this population. These behavior-observational instruments appear to have potential to help identify the pathways associated with community exclusion of youth with serious emotional or behavioral disturbances.

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The Daily Activities of Staff Employed at a Family Support Program Located in an Urban Setting

Authors

Introduction Method Results Discussion

Introduction

Kaleidoscope, Inc., in Chicago, Illinois, is a child welfare agency that provides unconditional, individualized, and, when necessary, wraparound services to over 600 children and families. The purpose of Kaleidoscope is to support or recreate the family by helping to develop or redevelop the love, care, and discipline of its members. The Satellite Family Outreach Program is one of the programs offered by Kaleidoscope. The primary goal of the Satellite Program is to help maintain referred children, parents, and siblings as an intact family unit. The families served by Satellite experience numerous difficulties and needs. Most are single head-of-household families functioning on incomes below the poverty level. Many have open cases with Illinois' child protection agency.

Although there is much interest in the methods child welfare agencies such as Kaleidoscope use in aiding their clients, there is very little research concerning the specific activities performed by the staff members of such agencies. The present study examines (a) the types of activities performed by the Satellite staff, (b) the frequency of the occurrence of these activities, (c) with whom the staff member were engaged in each activity, (d) where each activity occurred, and (e) the duration of each activity. The purpose of this study was to investigate how the clients of the Satellite Family Outreach Program are served by the social workers and family workers of Satellite.

Method

Setting

This study was conducted at Kaleidoscope, Inc., a non-profit child welfare agency in Chicago, Illinois. In January 1994, Kaleidoscope received a grant from the Annie E. Casey Foundation to evaluate its Satellite Family Outreach Program. This study is one component of the overall evaluation. The Satellite program serves approximately 48 families at any one time and employs a staff of four administrators, three supervisors, four social workers, and 16 family workers.

Participants

The Professional Activities Checklist (PAC) was completed at two time intervals: Time 1 (May/June 1995) and Time 2 (September/October 1995). At Time 1, 17 staff completed the checklist. Twenty-four percent (N = 4) of the respondents were social workers and 76% (N = 13) were family workers. Time 1 participants ranged from 23 to 54 years of age. The mean age was 32.4 years. A total of 71% (N = 12) of the Time 1 participants were female, and 29% (N = 5) were male. The racial composition was 53% African American (N = 9), 41% Caucasian (N = 7), and 6% Asian American (N = 1). At Time 2, 17 staff participated, four were social workers (24%) and 13 were family workers (76%). The average age was 32.9 years, ranging from 23 to 54 years. Seventy-one percent (N = 12) of the respondents were female; 29% (N = 5) were male. Forty-seven percent (N = 8) were African American, 41% (N = 7) were Caucasian, and 12% (N = 2) were Asian American. Thirteen staff members participated at both Time 1 and Time 2.

Instrument

The PAC was developed in three steps. First, evaluation team members met with a group of five Satellite staff members. The staff members were asked what activities they perform, with whom they perform them, and where they perform them. Based on the staff responses, the evaluators constructed a first draft of the PAC. Next, the evaluators met again with the group. Staff members provided feedback on the first draft and evaluators incorporated the appropriate changes into the PAC. Then, several staff members completed the PAC daily for three consecutive days in a pilot study. Based on this feedback, evaluators and staff noted any remaining inconsistencies, and the final version of the Professional Activities Checklist was then constructed.

The instrument consists of 19 professional activities in which Satellite's family workers and social workers engage (e.g., individual counseling, advocacy). For each day, the worker indicates how many times each activity is performed (i.e., the frequency). For each occurrence the worker indicates with whom the activity is performed (e.g., referred indicates with whom the activity is performed (e.g., referred client, other family members), where the activity is performed (e.g., client's home, community), and how long the activity lasts. The checklist takes about 10 minutes to complete.

Procedure

As stated, the study was conducted at two time intervals (Time 1 and Time 2). Each time interval spanned a five week period. Satellite staff are organized into teams comprised of one social worker and four family workers. One staff member from each team completed the PAC daily for one of the five weeks in the time interval. Staff members were given the PAC forms by an evaluation team member five days prior to their assigned week. The evaluation team member gave participants a reminder call on the first day that they were to complete the checklist. At the end of their assigned week, the participants returned the checklists to the evaluation team. If a participant was sick or not working on one of their assigned days, they completed the PAC for the same day the following week.

Results

To identify the professional activities of the Satellite staff, the frequencies per day per staff member and the time spent per day per staff member were examined. Findings are presented for both the frequencies and time spent for both time intervals (Time 1 and Time 2) and the differences between Time 1 and Time 2 in minutes spent per day on each activity.

At Time 1, the most frequently occurring professional activities were writing reports (1.51 per day), individual counseling (1.05 per day), and collateral contacts (1.00 per day). The least frequent activities were crisis intervention (0.02 per day), training (0.04 per day), relationship counseling (0.08 per day), and employment/vocational (0.08 per day). Staff spent the most time writing reports (111.97 minutes per day), counseling individuals (52.58 minutes per day), in meetings (49.12 minutes per day), making collateral contacts (44.42 minutes per day), and in transportation (39.01 minutes per day). Staff spent the least amount of time in crisis intervention (1.41 minutes per day), food depository (2.12 minutes per day), and housing (2.29 minutes per day).

At Time 2, the most frequently occurring professional activities per day were written reports (1.38 per day), collateral contacts (1.08 per day), counseling individuals (0.92 per day) and transportation (0.87 per day). The least frequently occurring professional activities per day were employment/vocational (0.00 per day), relationship counseling (0.04 per day), housing (0.04 per day), and training (0.05 per day). Staff spent the most time in writing reports (111.60 minutes per day), meetings (51.25 minutes per day), transportation (37.39 minutes per day), counseling individuals (35.52 minutes per day), and collateral contacts (36.47 minutes per day). Staff spent the least amount of time in employment/vocational (0.00 minutes per day), relationship counseling (0.89 minutes per day), housing (0.89 minutes per day), food depository (1.61 minutes per day), and resource referral (2.86 minutes per day). A complete list of the frequencies and the time spent on each activity at both Time 1 and Time 2 is displayed in Table 1.

Across the two time periods, there were very few differences. Activities that showed a substantial increase in time spent per day (i.e., more than four minutes) were family counseling (11.67 minutes), training (10.99 minutes), family visits (10.43 minutes), and advocacy (6.08 minutes). Activities that showed a substantial decrease (i.e., more than four minutes) in time spent per day were counseling individuals (-17.06 minutes) and collateral contacts (-7.65 minutes). The other 13 activities were relatively stable across the two occasions. A complete list of the changes in time spent between Time 1 and Time 2 is shown in Table 2.

Discussion

The findings of this study are useful in a number of ways. First, Kaleidoscope can examine the findings and determine whether the activities the staff engage in accurately reflect the mission of the Satellite Family Outreach Program. For instance, one goal of the Satellite Program is to help families stay together through intensive case management. Therefore, program administrators can use the Professional Activities Checklist data to determine how much time the workers are spending with the clients and whether this amount of time adequately meets the goal of intensive case management.

Second, the information indicates what types of services are used most frequently by clients. This outcome may enable the agency to further develop services tailored to the specific needs of their clients. For instance, as individual counseling and recreational activities are among the services most used by clients, program administrators may consider providing counseling training to staff members and incorporating counseling into recreational activities.

Third, the data on the professional activities of staff members may reveal some important information when combined with other research on the same staff members. For example, combining the analysis of professional activities with research on job satisfaction (another area we are currently studying) may reveal significant relationships between the two variables. For example, those who are frequently advocating for their clients may have a higher level of job satisfaction than those who spend their time in meetings, or vice versa.

Finally, these data may assist other agencies interested in providing wraparound-service programs. Specifically, these data outline the daily activities that are engaged in by staff who are following a wraparound model of service delivery; other agencies interested in following this model of care may be able to use these data when deciding what specific staff activities are necessary for the agency and its clients.

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The Youth Client Satisfaction Questionnaire: Measure Development, Factor Analysis, and Validation

Authors

Introduction Method Results Conclusions References

Introduction

Current thinking about the child mental health system emphasizes the importance of consumer satisfaction and a child-centered approach (Knitzer, 1982; Stroul & Friedman, 1986). Successful implementation of these principles requires a reliable and valid method of producing differentiated information about young people's satisfaction with their services. Efforts to develop such methods have only recently begun. Existing measures have been characterized as being limited by a lack of psychometric information, sampling problems, vulnerability to social desirability response bias, and a lack of differentiation among dimensions of satisfaction (Young, Nicholson, & Davis, 1995).

The Youth Client Satisfaction Questionnaire (YCSQ) was designed to differ from existing measures of this construct by combining several characteristics. First, this instrument is administered as a telephone interview, which provides a higher response rate than mailed surveys (Young et al., 1995). The YCSQ also provides differentiated information about dimensions of client satisfaction, and its directions and item wording are designed to minimize social desirability response bias.

Method

Participants were 150 clients and their parents who had completed therapy at a community mental health center for children in northeastern Ohio. The age range was 11-17 and the mean age was 13.23 (SD = 1.72). The sample was 51% female. Ethnic composition was 43% African American, 50% White, 5% Hispanic, and 2% other ethnic group. The sample included only subjects who had participated in at least three therapy sessions (not counting the initial diagnostic assessment).

The primary income source was employment for 37% of the families, with 63% receiving AFDC or another form of income assistance. A total of 62% of the families were headed by a single parent, and 38% of the families provided two-parent homes. Eighteen percent of the youth had a history of juvenile court involvement. At intake, 28% of the sample were diagnosed with Oppositional-Defiant Disorder, 8% with Adjustment Disorder with Mixed Emotional Features, 8% with Sexual Disorder Not Otherwise Specified (juvenile sex offenders), 6% with Dysthymic Disorder, and the remainder widely dispersed among a number of diagnoses.

Most subjects participated in a combination of treatment modalities, so that the following proportions add up to more than 100%. Seventy-seven percent of the subjects received individual therapy, 91% family therapy, and 22% group therapy.

Fifty-eight percent of the consumers eligible for the study became participants (N = 87). Only 34% of the attrition was due to client unwillingness to participate. The remainder of non-participants resulted from the family not having a phone, moves without forwarding information, the family's inability to complete the interviews by eight weeks from their last appointment, language barriers, and the child no longer being in the home.

Candidate items for the YCSQ were generated on the basis of a literature review, focus groups with clinicians, and individual exploratory interviews with 10 young clients and their parents. This resulted in 17 candidate items. The design of the YSCQ involved combining psychometric considerations with the need to maximize ease and comfort of responding. Responses were coded in the form of a four-point Likert-type scale. However, rather than presenting the scale directly to subjects, responses were obtained through very brief, scripted exchanges between interviewer and youth, with follow-up questions when necessary. The items were given different scale anchors, depending on the item content.

Telephone administration of the YCSQ usually took about 10 minutes unless there was spontaneous elaboration. One-half of the subjects responded to the questionnaire again in three weeks to assess reliability. One item was again in three weeks to assess reliability. One item was repeated as a reliability check. Five protocols were excluded because of evidence of random responding.

The procedure also included the Child Behavior Checklist (CBCL; Achenbach, 1991a) and the Youth Self-report (YSR; Achenbach, 1991b), which were administered prior to and after therapy as an assessment of outcome. Parents also completed a measure of their satisfaction with services (Kotsopoulos, Elwood, & Oke, 1989) during a telephone interview.

Results

Because YCSQ items have different anchors, there were questions about the parametric versus nonparametric nature of the data. In order to address this issue, we computed Spearman correlations for the psychometric analyses addressed below and compared them to the corresponding Pearson correlations. The 51 pairs of correlations were extremely similar, with no significant differences, suggesting that YCSQ scaling design does not result in marked departure from interval equality and item comparability, so that parametric procedures are appropriate for the data.

There were three criteria for retaining items in the measure: (a) test-retest reliability correlation ^{3} .50; (b) part-whole correlation ^{3} .40; and (c) correlation with a validation item about overall satisfaction ^{3} .30 (see Table 1). Fourteen items met these criteria. All correlations reported below are significant with $p < .0001$ unless otherwise indicated. The average reliability correlation was .67, with an average part-whole correlation of .65, and an average validity correlation of .48. The item with the highest part-whole correlation (.78) was the one about overall satisfaction. Total scores had a reliability correlation of .92. Cronbach's alpha was .90.

Total scores on the instrument ranged from 8 to 42, with a mean of 30.64 and a standard deviation of 8.11. The average item score was 2.19. Given an item score range of 0 to 3, these results indicate that the sample as a whole expressed a fairly high degree of satisfaction with their services&endash;a finding consistent with the general client satisfaction literature (Young et al., 1995).

We performed a principal components analysis with varimax rotation in order to identify the major factors of youth consumer satisfaction. Two factors emerged. The Relationship with Therapist factor included six items asking whether the youth liked the counselor, had a good time in therapy, perceived the therapist as understanding, caring, having helpful ideas, and as understanding his or her cultural group. The Benefits of Therapy factor included eight items asking about therapy-caused change in the areas of feelings, behavior, self-concept, personal problems, and family relationships, and asking about beneficial learning.

family relationships, and asking about beneficial learning, understanding therapeutic goals, and overall satisfaction. Cronbach's alpha for the individual factors was .85 in both cases. The inter-factor correlation was .66.

In order to assess convergent validity, we computed correlations between the YCSQ and several other measures of treatment quality (see Table 2). YCSQ scores were somewhat positively related to improvement from pretest to posttest on the CBCL ($r = .18$, $p < .05$), but not the YSR ($r = -.04$, ns). YCSQ scores had correlations of .37 with improvement in DSM III-R Global Assessment of Functioning scores, .41 with a therapist rating of treatment progress, .53 with parent satisfaction scores, and .47 with a parent rating of treatment progress.

Boys produced higher YCSQ scores than girls ($t = 2.00$, $p < .05$). There was a marginally significant correlation with age ($r = -.15$, $p < .07$). African American and White clients produced similar scores ($t = .29$). Client satisfaction did not differ depending on parental employment status ($t = 1.67$), single versus two-parent families ($t = .56$), past treatment history at our agency ($t = .58$) or another setting ($t = .59$), or youth involvement in the juvenile justice system ($t = .52$). YCSQ scores showed a marginally nonsignificant correlation of .16 ($p < .06$) with number of sessions.

The interview included two questions asking whether the youth wanted to receive counseling or if they were required to come. There was no relation between client satisfaction and whether the youth chose or were required to begin counseling ($r = .12$). Youth who reported voluntary participation in therapy by the time of termination were more satisfied with their services ($r = .50$).

Conclusions

The results suggest that the YCSQ is a reliable, internally consistent, and valid measure of satisfaction of mental health services for young clients, however, more research is needed. The 14 retained items demonstrated satisfactory psychometric properties and an interpretable factor structure suggesting that the relationship with the therapist and the perceived benefits of counseling are two main components of overall youth satisfaction. Youth client satisfaction showed significant relations with 5 of 6 other measures of treatment effectiveness (with the exception of the YSR), providing evidence of convergent validity for the YCSQ.

Telephone interviews proved to be a feasible method of administration. Given that mailed questionnaires often have low return rates and that terminations are often unplanned, the telephone method seems to have practical advantages. However, youth may not have felt the survey was anonymous when conducted by phone by staff from the center, leading to bias towards positive responses

The descriptive results suggest that most young counseling clients express a fairly high level of satisfaction with their services even when directions and items wording are designed to give permission for dissatisfied as well as satisfied responses. Clients who began treatment involuntarily ended with the same level of satisfaction as youth who initially wanted to receive therapy. Interpretation of these results should be cognizant of the possibility that clients who had dropped out prior to their third therapy session and those who were not recruited for the study may have had a lower level of satisfaction than our study participants.

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Adolescents and Providers' Perspectives on the Need and Use of Mental Health Services

Authors

Introduction Method Results Conclusions References

Introduction

The purpose of this study was to examine the need for and use of mental health services from both adolescents' and service providers' perspectives. This study examined the mental health needs of adolescents who interact with four types of service sectors that typically function as gateways to mental health services (i.e., education, child welfare, juvenile justice, and primary health). We compared prevalence estimates collected from the youths themselves to counts of clients kept by the gateway providers and comments made in focus groups by these providers regarding their understanding of mental health service issues. By comparing these three sets of data, we obtained a unique picture of the relationship between the services offered to youths, the youths' need for services, and the understanding of that need by the providers.

Method

The Youth Services Project, funded by the National Institute of Mental Health, examined adolescents' mental health needs and their use of mental health services. The Youth Services Project (a) interviewed youths (N = 796) from St. Louis city juvenile justice, education, primary health care, and child welfare sectors (approximately 200 youth per sector); (b) gathered anonymous counts of the mental health clients from each sector; and (c) conducted focus groups with providers from each sector. All four gateway service sectors were in a position to screen youths for mental health problems and to either provide some mental health services or refer to services elsewhere.

Data Sample

We recruited subjects with the aid of service providers, by having interviewers approach youths in the service sector waiting rooms, and by letters and posters requesting volunteers from each sector's service users. The interview participants were all between 14 and 17 years of age, with a mean age of 15.3 years. Thirteen percent were white, 86 % Black, and 1 % of other ethnic background. Forty-three percent were male, and 57 % female. The occupation of the parent who provided the most financial support to the family in the last 6 months determined the youth's socioeconomic status. Accordingly, 15% were welfare recipients, 3 % laborers or semiskilled workers, 23 % blue collar, 14 % white collar, and 39% professional.

Data Sources

The first source of data came from highly structured interview protocols which yielded information concerning: (a) demographics; (b) social and academic behaviors; (c) mental health; (d) service use; and (e) family, social, and community environments. Measures of mental health problems came from the Diagnostic Interview Schedule for Children-Revised (DISC-R: Schaffer, Schwab-Stone, Fisher, Cohen et al., 1993).

The second source of data was derived from service sector tallies of those adolescents were sector clients during the same period in which we recruited and interviewed our service sample. These were anonymous counts collected by the service providers, detailing the demographics of adolescent health service users and their mental health problems. For a one month period during the six month interview field work, service providers at each sector (except primary health) completed an anonymous tally sheet indicating the age, gender, race, and type of mental health problem of each consecutive youthful client. The health care sector already had such information as part of their billing records, they provided to us for that one month period. Pre-printed tally sheets were distributed to sector providers in order to maximize the ease and accuracy of tally-keeping by the service providers.

by the service providers.

The third and final source of data came from focus groups held with service providers from each sector. Their professions varied in accord with the sector: medical doctors and nurses from the Health Sector, social workers from Child Welfare, deputy juvenile officers from Juvenile Justice, and counselors and social workers from Education.

Results

Youths' Need for Services

The percentages of youths meeting criteria for a diagnosis of depression ranged from 8% to 17% depending on the sector providing services; for conduct disorder, the range was 8% to 30% ; and finally, for substance dependence/abuse, the range was 5% to 27%. The range for suicidality was 7% to 17%.

Services for Mental Health Problems

Our interviews indicated that, in general, half of the youths with mental health problems reported being helped by the gateway sector where we recruited them (see Table 1). However, the rates varied by sectors. The health sector interviewees reported the lowest service rate among all sectors, with less than one fifth of youths with problems receiving services. In the child welfare sector, the percentages of youths who had problems and who received help ranged from 54% to 64% depending on the mental health problem. In the education sector, the percentages of interviewees reporting services ranged from 50 to 80%. The highest percentages of mental health services were reported by interviewees from the juvenile justice sector, with a range from 80 to 95%.

Comparison of Interviews and Anonymous Counts

Table 1 allows the reader to compare percentages for the following: (a) the percent of interviewees identified as meeting criteria for diagnoses of a mental health problem; (b) the percent of interviewees who were having significant symptoms of such a problem; and (c) the percent of sector clients identified through the anonymous counts as having such problems.

In the child welfare sector, the counts (when compared to the interview data) underidentified youths with drug or alcohol abuse problems

(1% versus 17%). In contrast, the child welfare sector counts overidentified youths as having significant conduct disorder problems (46% versus 17%), but approximated the same rates as the interviews for suicidal youths (18% versus 17%) and depression (19% versus 17%). Within the juvenile justice sector, the anonymous counts identified similar percentages of mental health problems to those found in the percentages of mental health problems to those found in the youth interviews. The education sector tally underidentified clients as having problems with drugs or alcohol (0.1% versus 5%), being suicidal (0.7% versus 8%), and being depressed (3% versus 8%), but overidentified behavior problems (14% versus 8%). For the 227 consecutive adolescent patients tallied by providers from the health care sector, none were identified as having any mental health problems.

Focus group comments

Many of the comments offered by the providers during the focus groups/interviews gave significant clues as to why their particular sector did or did not identify or serve youths who had mental health problems. The juvenile justice sector, which had the highest rates of identification of problems, also had a special diagnostic and screening unit attached to it. Although the workers participating in the focus group reported that providing mental health services was outside their scope of activities, they were aware of the necessity for mental health assessment and even commented that watching office interactions was particularly helpful to them.

The child welfare sector had the next highest rate for identification of problems. Those workers also commented that providing mental health services was outside their scope of action. Nevertheless, they felt that they should identify such problems. They pointed out that car rides with the teenagers promoted freer discussion and were thus particularly helpful in assessing the youths' mental health problems.

The educational sector had particularly low identification rates for drug and alcohol abuse and suicidality. The providers reported that it was hard for them to identify mental health problems because parents and the community often denied that the problems existed. They also identified lack of time and very heavy caseloads as barriers to identifying youth problems. They also reported that the absence of support groups for adolescents with mental health problems kept them from identifying and referring for such problems.

The health sector identified no youths as having mental health problems. Of all the sector focus groups, health care workers, when asked about the kinds of problems their adolescent clients had, did not list one behavioral or mental health problem. They also mentioned that they lacked competence in assessing and treating mental health problems, and were uninformed about available resources for referral. When they referred youths for care, they felt that the long waiting periods for mental health appointments (up to one month) was a significant barrier. The health care workers also mentioned their concern with lack of continuity care.

Conclusions

The interviews showed that significant numbers of youths at each of the four sectors had mental health problems. However, only a limited percentage of those youths with mental health problems received services from their gateway sector. This percentage varied widely by sector, with the juvenile justice, education, and child welfare sectors providing services to a much higher percentage of youths than the health sector.

The anonymous counts paralleled the interview data. The juvenile justice sector tally reported the highest number of clients with problems. The child welfare sector tally identified a somewhat lower rate as having problems, despite the interview data showing an excellent record for services. The education sector had a very large discrepancy between the youths' interview data and the providers' tally data, although many of the youths with mental health problems felt they were receiving help. The health sector had the worst service record from both interview data and providers' tally data.

This study focuses attention on several important issues for service delivery. Many of the adolescents report that their gateway providers (e.g., school counselors, physicians, child welfare workers, or deputy juvenile officers) neither provided services nor informed them that care might be available. Further, many of the providers' records indicate unawareness of the extent of need. This would indicate that the gateway providers' perception of need (although often inaccurate) may determine the youth's pathway to services more than actual need and service availability. We must therefore educate gateway providers in diagnostic and assessment procedures, known incidences for mental health problems, service skills, service availability, and referral procedures.

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